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#### COVER STORY



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#### **Year 2000 Computer Compliance: How Will This Affect You Doctor?**

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By now, everyone has heard the horror stories surrounding "Y2K" the catch phrase of the late '90s. Countless prognosticators predict that when January 1, 2000 strikes, planes will fall out of the sky, elevators will screech to a halt, businesses will be paralyzed, and lawsuits will be filed left and right. Could it really happen?

More importantly, how are you preparing for the coming millennium? Presently, almost all medical equipment, and office or hospital filing and billing systems, are computerized. Are your vendors up to par regarding the Y2K problem? Are you? Find out how to cover your assets, protect your patients, and prepare for the coming year.

By Kathleen Farrell

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#### The Business of Medicine: Physicians Head Back to School

Today, having a medical career also can mean running a sophisticated company. Many doctors are choosing to learn now what they didn't learn in medical school about the business of medicine. By Lisa Weatherford

January 1999 Volume 98, Number 1

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#### Praise for Proposal B Defeat

Please convey to Cathy Blight, MD, the other officers, the Board, and the entire staff of MSMS my congratulations and heartfelt appreciation for their superb efforts in overwhelmingly defeating Proposal B and for the sweet elections of Justice Taylor and Chief Judge Corrigan! It is encouraging when physicians clearly articulate what we believe and what we stand for, and then go on to act upon our beliefs.

I am particularly appreciative of the values and of the actions of John English, MD, and Tom George, MD, both of whom know what a physician is and both of whom act on their convictions.

Sincerely,

Louis R. Zako, MD

Getting Out the Vote

We delivered an unbelievable 77 percent of voters from Berrien County against Prop B. The state wide grassroots effort in this was incredible. This hopefully will serve as a reminder to physicians of the potential influence we have.

Kenneth J. Edwards, MD

**Kudos for Ambulatory Center Article** 

I just wanted to let you know that I appreciate the fine article on ambulatory surgery centers written in the April 1998 publication of Michigan Medicine. I think the author did a fine job in conveying the facts to the medical community.

Many thanks again. A job well done.

Sincerely yours,

Gregory G. Messenger, MD

#### **Comment Line**

The editorial staff at Michigan Medicine is interested in your opinion on our stories. Please share your thoughts and ideas with us via telephone, fax, email or mail. Send comments to

Kristen Lare, managing editor **MSMS** 120 W. Saginaw St. East Lansing, MI 48823; or (517) 337-1351; (517) 336-5797 (fax); or klare@msms.org.



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#### How Can MSMS Work for You?

By Randy Gavorin

#### What is MSMSNET?

MSMSNET is the official Internet homepage of the Michigan State Medical Society. The address is http://www.msms.org.

#### What is the range of information and topics available on MSMSNET?

You can choose from eight main topics available on the mainpage. These are Medigram and Michigan Medicine, Political Action, Education. What's New and Site of the Week, MSMS Resources, Medical Economics, Medical Links, and the MSMS Master Calendar.

#### What sites would you recommend visiting on MSMSNET?

Medigram is among the most popular sites. Read Medigram online before you receive the printed copy to get up-to-date information.

The "Site of the Week" has a new selection every week regarding current issues.

#### How can I find the information I am looking for quick and easy?

We have designed the mainpage for streamlining. Our Java Applet on the mainpage offers basic sitemap. In addition, a search engine for MSMSNET is available to enhance

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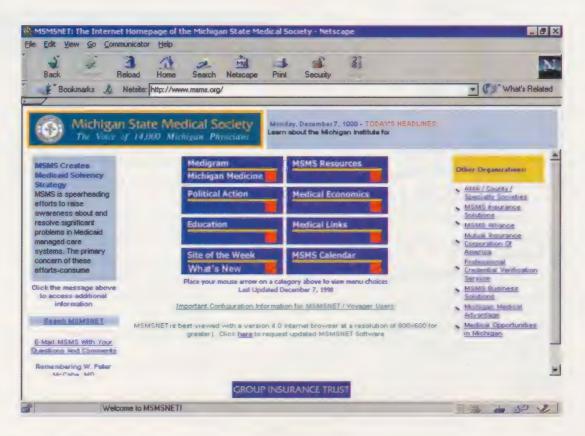
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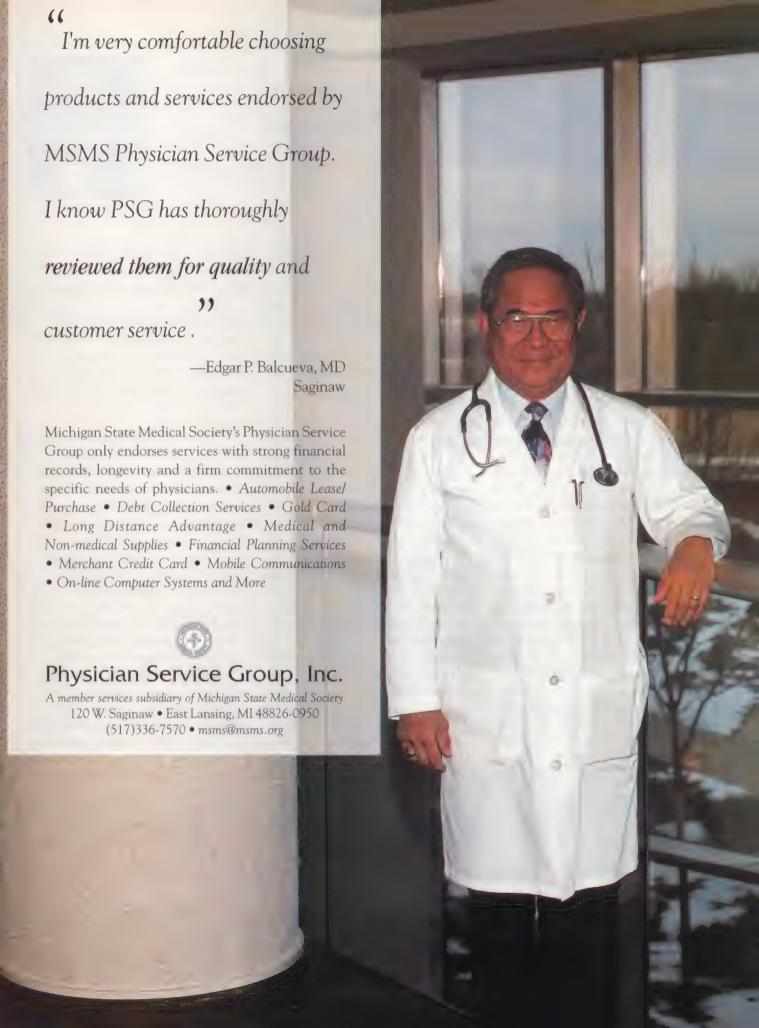
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# Medicaid Reimbursement and Timeliness of Payment

By Richard D. Weber, JD

MSMS legal counsel



**Question:** Fees paid to physicians for Medicaid services are often inadequate to break even. To further compound the problem, physicians are made to wait unreasonable amounts of time before payment is received. I know many physicians who simply cannot afford to treat Medicaid patients, notwithstanding their desire to provide services to the poor. Other physicians perform Medicaid services at considerable cost to their practice. Can you please explain the legal requirements with respect to Medicaid reimbursement and payment and advise whether there is any recourse?

#### Answer:

Medicaid is a cooperative federal/ state program through which the federal government grants funds to participating states to provide health care services to the needy. State participation is voluntary, but if a state chooses to participate in Medicaid, it must comply with the requirements of the Federal Medicaid Statute.

Federal law mandates states "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." This obviously focuses the issue on access to care by Medicaid recipients, as opposed to payment criteria that are applied in other reimbursement arrangements which focus upon the reasonable value of the charges established by physicians.

The federal statute also requires that a state Medicaid agency pay 90 percent of all claims within 30 days and 99 percent of all claims within 90 days after receipt of a clean claim. This same statute is carried over in the Medicaid Managed Care Legislation, which requires timely payment consistent with the 90 percent/30 day, 99 percent/90 day requirements.

If the evidence established that these federal statutory mandates were not being met, a federal court would have the authority to enforce them against the state. There is limited authority in other jurisdictions on this issue. For example, the Arkansas Department of Human Services issued a rule cutting reimbursement rates to Medicaid providers by 20 percent to offset a \$60 million shortfall in that state's Medicaid budget. The Arkansas Medical Society and other associations and physicians filed suit. The federal court concluded that the Arkansas plan was invalid under the federal statute on the grounds that the state failed to consider whether the proposed reimbursement rate reductions satisfied the federal statute. The court ruled that Arkansas failed to determine whether the rate cuts were consistent with efficiency,

economy, and quality of care, and whether the cuts would adversely affect Medicaid recipients' access to health care services. The federal court required the state to establish the plan to conform to the federal law. Although this case addressed the process by which the state implemented rate reductions, rather than the adequacy of reimbursement rates, the analogy is clear.

The Medicaid problems raised in the question are so significant that the MSMS Board has directed legal counsel to further research the legal issues to determine whether a judicial remedy would be appropriate. To successfully litigate these issues would require evidence to support a violation of the federal statutes by the state Medicaid agency. More specifically, it would require evidence that Medicaid recipients were not receiving access to medical care to the extent available to the general population. This would obviously require, among other things, testimony from Medicaid recipients themselves. In addition to the substantial legal issues implicit in such a major state-wide lawsuit, the public relations issues would require careful analysis.

A legislative solution has not been satisfactory. MSMS has vigorously lobbied the Michigan legislature for improved reimbursement under the Medicaid program. The response has consistently been based upon budget constraints, but this is not a defense under the fed-

**Editor's note:** If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Kristen Lare, managing editor, P.O. Box 950, East Lansing, MI 48826-0950.

eral statutes. States must comply with the federal mandates, notwithstanding budget constraints.

The author is senior partner with Kerr, Russell, & Weber, Detroit.



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No. MSMS' ISP is Voyager. However, MSMSNET Internet Service enables physicians to communicate with the world through Voyager. We recommend Voyager as your ISP for several reasons. For \$18.95 per month, you receive unlimited access, dial-up local numbers throughout Michigan, and the ability to send and receive email using an "@msms.org" address. A subscription also includes two additional email addresses, 5 mb of free Web space to develop a homepage for business-related content or entertainment, and technical support from Voyager and MSMS.

#### How can users contact MSMS with questions and comments?

The mainpage contains a link called "email MSMS with Questions and Comments" that enables users to send messages directly to MSMS staff. Comments are welcomed and reviewed daily.

For further information, contact Randy Gavorin chief of Internet Systems, at (517) 336-7594, or rgavorin@msms.org.

The author is chief of Internet Systems at MSMS.

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## **Making Medicaid Viable** for the 21st Century

By Dustin May

MSMS has worked tirelessly to secure cost-effective quality health care to Michigan's Medicaid patients. In 1996, a state initiative moved Medicaid into managed care with the assurance that physicians would be directly involved in and beyond the transition process. As expected, costs increased when new covered benefits were added, but reimbursement from state and federal governments has decreased.

As a result, physicians are being compensated at less than the already low rates and must suffer lengthy delays. Today, physicians must accept reimbursement at 31-35 percent of the actual cost for the service. Michigan's physicians face the dilemma of staying in practice or turning away Medicaid patients. Michigan physicians must send a message to the legislature when they begin drafting the Michigan Department of Community Health fiscal year 2000 budget—don't force us to turn away Medicaid patients.

#### **Medicaid's Economic Paradox**

The federal government does ensure that Medicaid's covered benefits and enrollees do not exceed the system's budget, but it does not have oversight on how provider payments are administered. Furthermore, Michigan's strong economy has led the federal government to give fewer Medicaid dollars to Michigan. Because of rising per capita income, the Federal Medical Assistance Percentage (FMAP), which determines the amount of money the federal government will contribute to the program, has dropped from 56.84 percent to 53.58 percent in four years. With President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry implementing a patient's bill of rights for all federally funded health plans, new benefits were mandated as well.

These mandated procedures included coverage for access to specialists and access to emergency services. However, with fewer total dollars coming into the Medicaid system and more procedures being performed, the managed care apparatus reimbursing the physician inevitably pays less. Compounding the economic challenge to physicians are the costs of maintaining a practice, which

are rising at 8 percent per year. The financial disincentive to cover Medicaid patients increases every year. Physicians' moral obligations to treating these patients are being stretched to limit. It will not be soon until Medicaid patients will be turned away. "The current Medicaid system of low reimbursement," says Detroit physician, Cecil Jonas, MD, "encourages less care to a population that, in most cases, requires more care. It is unfortunate that, in these times of supposed prosperity, the Medicaid population is being treated like second class citizens."

David Share, MD, of Washtenaw County encounters the inadequacy of Medicaid reimbursement every day. Not only does it prevent physicians from providing quality care, he says, it also prevents physicians from preventing more serious health problems that inevitably raise costs in the future. "The reimbursement levels are so low that they only cover the cost of 'Band-Aid' care. There is no reimbursement or incentive to find new ways to prevent health problems or optimize the quality of care."

#### Fewer Dollars, More Paper

When Medicaid was turned over to managed care administration in 1996, physicians were promised inclusion in the transition to assure continuity of care and patient access to a stable, user-friendly health care environment. The program, Physician Sponsor Plan (PSP), contracts with Qualified Health Plans (QHP) that now reimburse physicians have resorted to paying physicians on antiquated fee schedules and unreasonable capitation fees. G.H. Mir, MD, of Benton Harbor explains that "a plan that pays \$4-9 per pediatric patient per month as the capitation fee for professional care is reimbursing 25 percent less than commercial for the same patient and care. It is inconceivable for any person to accept 15-30 cents per day payment in full—for the professional care of a pediatric patient by a pediatric MD."

Physicians encounter more than just low reimbursement rates when treating Medicaid patients. As many physicians can testify, administrative headaches often arise when making claims. Too often Medicaid reimbursement is delayed or bogged down with administrative red tape. One of the largest problems is with unreimbursed claims. Some physicians have outstanding Medicaid accounts dating back as far as a year—up to and exceeding \$50,000. One group of emergency room physicians has outstanding accounts from numerous OHPs that add up to \$600,000!

One of the most inflammatory issues with any governmentally funded program is fraud and abuse. Since Medicaid reimbursement has come under the powerful microscope of the Department of Justice, many physicians have encountered increased sensitivity to simple coding mistakes and highly punitive enforcement of fraud and abuse statutes. In the last four years the Department of Justice has increased resources, focused investigative strategies, and improved coordination among law enforcement to fight health care fraud. As a result, the number of health care fraud convictions increased by more than 240 percent since 1992. Increasing scrutiny of the fewer Medicaid dollars available is quickly becoming another incentive not to treat the patients the government insists its trying to protect.

#### Its Time to Act

The Michigan Department of Community Health year 2000 budget will begin its trip through the legislative process on February 1, 1999, and will be in final version by mid-summer. Then will be the time for Michigan's physicians to unite and send a message to state legislators that by not restoring Medicaid reimbursement to practical levels, they will hurt not only organized medicine, but the entire Medicaid system. As Daniel J. Wilhelm, MD, and chair of the MSMS Medicaid Liaison Committee said. "The Michigan legislature and administration are acting irresponsibly by not appropriating even an inflationary increase for physician services. This may be the straw that breaks the camel's back."

Michigan currently ranks 40th in the nation for Medicaid reimbursement.

#### To support this effort, MSMS is undertaking the following initiatives:

- Organizing physician meetings with key lawmakers to enlist their support
- Implementing a media campaign to promote public awareness of Medicaid funding deficiencies
- Providing members with the means to advocate for their patients and their profession
- Working with a coalition of consumer organizations to create a better Medicaid system
- Urging physicians to contact their state legislators.
- Collaborating with the Michigan Association of Health Plans, Michigan Health and Hospital Association, Michigan Osteopathic Association, Primary Care Association of Michigan, and Long Term Care Association of Michigan to improve funding of the Medicaid system

For more information, contact Greg Aronin, Government Relations director, at (517) 336-5739 or at garonin@msms.org. Christine Shearer, chief of State Government Affairs, may also be of assistance at (517) 336-5737, or at cshearer@msms.org.

The author is an East Lansing-based freelance writer.

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# ISSUES BRIEF

Tear this article from the magazine and share with colleagues or file for reference. This issues brief is part of an important series of backgrounders prepared for MSMS members. Look for future briefs in coming issues of Michigan Medicine. The briefs also can be found on the MSMS Website at www.msms.org. Please contact MSMS at (517) 337-5748, or msms@msms.org. for additional copies of this brief for your patients and colleagues.

### **HMO Insolvencies:** Physicians Left Holding the Bag

What happens when a Health Maintenance Organization (HMO) is unable to honor its obligations to its creditors and subscribers? Surprisingly, the answer is not at all clear. Section 109 of the United States Bankruptcy Code ("Code") provides that a person may be a debtor under Chapter 7 or Chapter 11 only if such person is not . . . a domestic insurance company. HMOs have many indicia of insurance companies, and several courts have concluded that an HMO is an insurance company and thus precluded from sustaining a case under the Code. However, other courts have arrived at the opposite conclusion. Specifically, in Michigan, In Matter of Michigan Master Health Plan Inc., 90 BR 274 (ED Mich. 1985), rev'g 44 BR 642 (Bankr.ED Mich. 1984), the court gave unqualified deference to the Michigan Attornev General's position that an HMO was not an insurance company under Michigan law.

HMOs are steadily gaining a larger share of America's health care market, and have been touted by many as a remedy for the ills of our nation's health care system. The ability of HMOs to control their own costs is viewed as the key to their relative financial stability. Yet, the HMO industry is not immune from financial peril, and during recent years, a number of HMOs have become insolvent and undoubtedly others will become insolvent in the near future.

In the event an HMO becomes insolvent, "hold harmless" clauses in the contracts between the HMO and its' providers force providers to look solely to the HMO and not the enrollee for payment of their fees; therefore, shifting the risk of loss to the providers. Therefore, if the HMO becomes insolvent or declares

bankruptcy, the physician provider is bared from seeking payment from the person who received the services. In such a case, the provider has no alternative means to collect the unpaid claim except by filing a proof of claim in the bankruptcy court. The hold harmless provisions in effect shield the plan member from individual

Factors such as increased competition, unanticipated increases in ambulatory costs, inadequate Medicare payments, poor management, and a lack of financial reserves have forced a number of HMOs into bankruptcy: thus, making financial stability a crucial ingredient to surviving in today's competitive and volatile health care market. A survey by the Solvency Working Group of the National Association of Insurance Commissioners found that providers are owed an average of \$2,005,000.00 at the time of HMO insolvency.

An HMO provides or arranges for care while shifting degrees of risk for financial loss to the medical care providers. In addition to hold harmless clauses, risk-transferring techniques may include, established cost containment incentives utilization controls, and organized compensation arrangements. In a staff model HMO, risk transference may take the form of incentive arrangements or bonuses to physicians based on their performance.

One way the federal government has attempted to ensure the financial stability of an HMO is by implementing minimum criteria, which an HMO must meet to be federally qualified. Among them, the federal HMO Act's organizational requirements compel an HMO to posses "(1) a fiscally sound operation, and (2) adequate protection against the risk of in-



solvency..." The HMO Act also prohibits enrollees from "incurring liability for payment of any fees which are the legal obligation" of the HMO.

HMOs seeking to achieve qualified status under the HMO Act must additionally comply with regulations promulgated by HCFA. The fiscal soundness must be proved to the Secretary by generally demonstrating that assets are greater than liabilities and that a net operating surplus exists. Of importance to providers, a federally qualified HMO must possess a plan that continues benefits to enrollees in the event the plan becomes insolvent. Further, the regulations require the HMO to take steps to assure that members are not held liable for any fees that are the HMO's legal obligation. However, the regulations provide no guidance as to the procedures to be followed in the event of an insolvency of an HMO.

Also, the HMO must maintain a plan to ensure that services will not be interrupted in the event of insolvency. An approved plan mandates provisions in provider contracts that require the continuation of the provider's services for which payment has been made, despite an HMO's insolvency.

However, providers are given some protection under the bankruptcy laws. Specifically, providers subject to a hold harmless clause are allowed priority after that of enrollees and enrollees' beneficiaries, and immediately proceeding the priority of distribution described in the insurance code of Michigan. In other words, the HMO member is granted priority over the provider's claim as a creditor, and the provider, subject to a hold harmless clause, receives priority over the claims of other creditors.

Perhaps most important to a health care provider is that they are prevented from terminating a provider agreement with an HMO that becomes insolvent or seeks bankruptcy protection, notwithstanding the fact that a provider may have bargained for a termination or notice provision in the provider agreement. Thus, this usually very valuable "termination upon notice" clause cannot be used. Attempting or threatening to terminate may even subject a provider

to penalties for a violation of the automatic stay. A provider therefore generally must continue to render services pursuant to the provider contract until the debtor decides whether to assume or reject. The debtor generally has the period of time until the plan of reorganization is approved to make a decision. A provider should acknowledge this undetermined time period, of potentially uncertain financial risk, when considering forming a relationship with an HMO of unknown financial stability.

However, a provider who continues services during this period is not without remedy. An administrative priority is granted for the value of services provided during the post-petition period. These claims are superior to prepetition unsecured claims. Although providers may have to wait for payment, these claims must be paid in full upon confirmation of a plan of reorganization. The only class with higher priority, holders of secured claims, generally does not constitute a major portion of an HMO's debt.

Michigan State Medical Society can help you possibly avert the tragedies of an HMO bankruptcy by providing you with information to determine the financial stability of a health plan. MSMS' Evaluation of Health Plans and contracting checklist can help you understand the specifics of a contract between you and the HMO "before you sign on the dotted line." The information provided herein should not be construed as legal advice or a substitute for competent counsel.

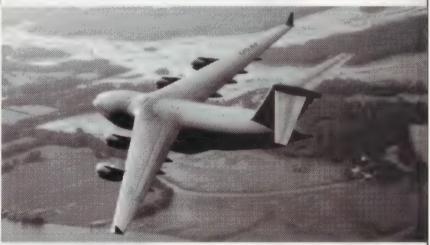
#### For Further Information

For further information, please contact Charles R. Cuzydlo, JD, MSMS Chief of Legal and Regulatory Affairs at (517) 336-5714 or ccuzydlo@msms.org. Or check out our Website at http://www.msms.org.



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## Charles Gehrke, MD

Helping Healers Heal Themselves

#### By Ralph D. Ward

or many of us, drug and alcohol abuse becomes serious only when the addiction of ourselves or someone we love forces the concern to a personal level. Charles Gehrke, MD, faced such pain himself. Though he learned how addiction hurts, and how it can be healed, he has done far more to address the issue. Using the same drive and innovation that made him a pioneer in Michigan's Physician Organization (PO) structure, he now helps fellow physicians overcome their substance abuse problems.

Charles Gehrke has built a distinguished career in Michigan since his graduation from the University of Michigan Medical School in 1962. He established a noteworthy practice in hematology and oncology, and is currently in practice in Saginaw, where he is a vice president at St. Mary's hospital. Before 1992, however, Doctor Gehrke was affiliated with St. Joseph Hospital in Ann Arbor. In 1983, while with the Department of Internal Medicine there, he was active in forming a Physician's Organization, the Huron Valley Physicians Association. "This was one of the first POs in the state," Doctor Gehrke recalls, "and I was the first president."

#### Helping People in Need

In recent years, though, Doctor Gehrke has added the field of addiction medicine to his portfolio. "Similar to roughly 90 percent of physicians in the field, I became involved in dependency issues because of a family member who was involved with drugs and alcohol. At the time, we found there were very limited treatment facilities in the state, or even treatment beds. And as surprising as it seems, there wasn't anything at all in Washtenaw County."

In the mid-1980s, Doctor Gehrke joined with

other physicians who had noted this lack of treatment options, and formed a task force at St. Joseph's hospital to address the issue. The result was the formation of the St. Joseph's Huron Oaks chemical dependency program. The physicians also proposed an extension of the Huron Oaks project to meet the specific needs of teenagers battling alcohol and drug problems. "The usual 28-day residential program just isn't long enough for adolescents. They need extended care and support for treatment to

be effective—up to six months." The hospital responded with Alpha House, a sub-project to meet the long-term needs of addicted kids.

#### **Meeting New Challenges**

His work with dependency issues exposed Doctor Gehrke to the special treatment challenges faced by physicians and other health care professionals, "I chaired the MSMS Committee to Assist Impaired Physicians on and off for several years," Doctor Gehrke notes. But, despite much good work done by the Committee, he and others found that health care professionals in trouble needed more. "The Committee had no legal standing, and there was no recognized treatment track. [Physicians] still ended up going through the disciplinary procedure."

In 1994 a new state law addressed the unique substance abuse demands of health care professionals, and mapped out a complex structure to meet the dual needs of confidentiality and effective treatment. A state Health Professionals Recovery Committee oversees a statewide program under a corporate entity that monitors, oversees, and contracts the actual counseling and recovery work. This structure, the Health Professionals Recovery Corporation

(HPRC), is headquartered in Brighton, has a staff of 15, and will soon gain a new medical director-Doctor Gehrke. "This entity is completely freestanding, with its own board. bylaws, and governance," notes Doctor Gehrke. The HPRC program has the staffing and expertise needed to contract and supervise recovery programs for all the health professions mandated in it's charter. Along with physicians (both MD and DO). these include dentists, nurses, pharmacists, chiropractors, medical assistants, and even veterinarians.

Despite their wide variety of roles in health care, Doctor Gehrke finds that all these licensed professionals share

unique problems in coping with substance abuse. "Among health professionals in particular, chemical dependency is a greatly underrecognized and undertreated disease. There's still a great stigma attached." Doctor Gehrke recalls a physician friend who was a functioning alcoholic for 20 years, and also an avid private pilot. After his recovery and treatment, he sought to renew his flying license, but honestly noted on his application that he was a recovering alcoholic. "They wouldn't renew his license because he was recovering yet he'd been flying as an alcoholic for 20 years."

#### Physician Advantages

Despite the added pressures facing a physician with substance abuse problems, Doctor Gehrke finds that doctors seeking recovery have a few advantages over the general population. "They really don't want to wait until they get in trouble, or get caught with their judgment



impaired. They tend to want treatment early so they can get back into the mainstream of practice." The new carrot-and-stick approach to recovery for impaired physicians also gives them stronger incentives than most of the public to deal with their problem early. "They don't want to lose their ability to practice. It's an important part of their identity, not to mention a pretty adequate income." This professional standing, as well as the incentives to early treatment, also means that physicians are less likely to hit rock bottom before seeking care. "They still have some sort of a social structure intact. they're not living on the streets."

Doctor Gehrke finds that physicians bring their sense of responsibility with them into recovery, to good effect. "Their recovery rate is much higher than that of the general population. Recovering physicians are really neat people."

The author is a Riverdale-based freelance writer.

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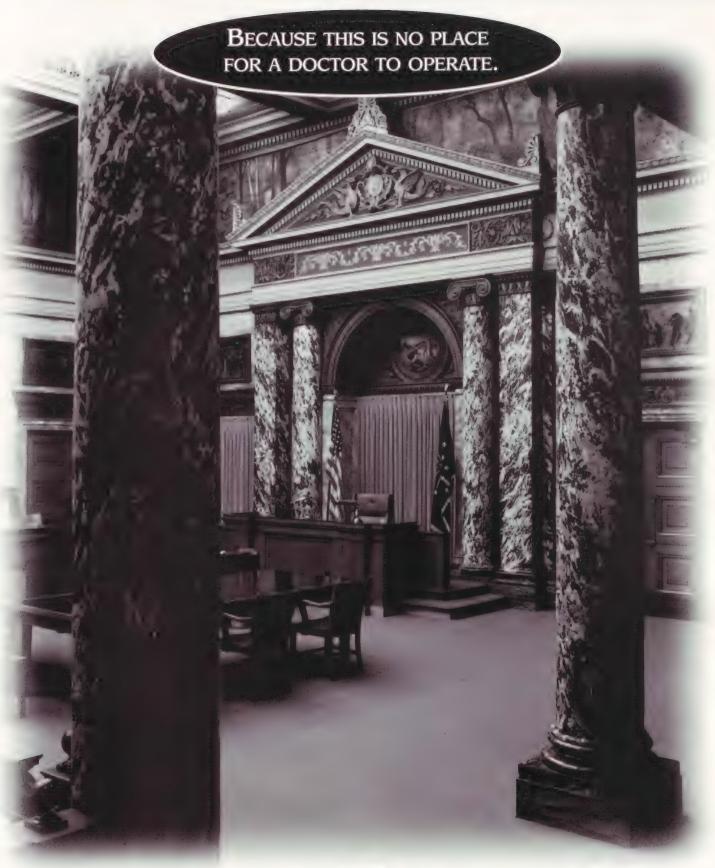
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# YEAR OF THE PROPERTY OF THE PR



# **Computer Compliance**

How Will This Affect You, Doctor?

By Kathleen Farrell

the catchword of the '90s. Countless prognosticators predict that when January 1, 2000 strikes, planes will fall out of the sky, elevators will screech to a halt, businesses will be paralyzed, and lawsuits will be filed left and right. Could this all happen?

Michigan Medicine January 1999 25

For the health care community, the Y2K issue literally can have life or death ramifications.

Probably not, maybe, and highly likely. Depending on how you choose to address the problem, it may turn out to be a minor, fixable inconvenience, or a major disaster. But one thing is for sure—if you ignore the "Y2K bug," you will find yourself in big trouble when the millennium arrives.

For the health care community, the Y2K issue literally can have life or death ramifications. According to a recent article published by the American Medical Association (AMA), nearly every piece of medical monitoring equipment today relies on some kind of embedded microchip. Therefore, every single technological device found in every medical office must be examined to ensure it is Y2K compliant. Any number of things can happen involving patient care—pacemakers that don't work, life support systems that fail, even the day-to-day running of your practice could become a nightmare. But like any entity dependent upon modern technology, the fix is still the same—awareness, education, and action.

#### Why is This Happening?

The problem originated years ago when computers were being developed. No one thought we'd still be using the same types of systems when the millennium arrived, so no one had the forethought to input dates with four digits instead of two. Now, when January 1, 2000 hits—computers won't be able to recognize what year it is, which will send unknown numbers of pieces of equipment into a date-induced frenzy. The solution is to replace the millions of computer chips embedded in systems throughout the world with updated parts. It's an expensive, long, tedious, but very necessary process. Complicating matters is the fact that our vendors must also be compliant.

A recent study by the Gartner Group, Inc., known as a watchdog of the information technology industry, reports that 40 percent of companies worldwide will experience "mission-critical information technology failure" because of the Y2K problem. According to Jim Duggan, research director for Gartner, there is a significant variation in Y2K preparedness in different industry sectors. The private sector generally is more prepared than government; large businesses better prepared than small; and the financial sector more prepared than engineering, transport, services, or construction industries. Overall, Gartner reports that the Y2K situation won't cause the worldwide business meltdown that many analysts have predicted, but that it will have a negative impact on the world economy, which will still be evident in three to five years.

#### Where Do You Fall on the Spectrum?

The report studied each country for Y2K readiness and then ranked them from Level 1-4—one being the best. Fortunately, the United States ranked under Level 1. Unfortunately, when the study predicted corporate failure rate by industry, health care fell into Level 4, the worst category.

The key to surviving Y2K is to be prepared, and to start now. "If you haven't started, you're already behind," says Kevin Lutz, vice president and chief technology officer for the AMA, who suggests health care professionals try to become educated. "Seek professional help because chances are [physicians] don't have the internal staff to deal with the situation." Fortunately, many consulting groups today have knowledgeable professionals who can guide clients through their Y2K woes.

#### Is Your Vendor Compliant?

Blue Cross/Blue Shield of Michigan (BCBSM), which processes millions of claims every year, started their Y2K preparations all the way back in 1995. "All in all, we thought that if we didn't have these things completed, then we wouldn't be able to continue business at the level we want to," says Paul Gliesman,



Y2K Project Director for BCBSM. "We thought if we're going to get outside help, which we did, we wanted to start early so we wouldn't get caught in the shortage of resources."

As of October 1998, BCBSM had completed its Y2K "fix" for the company's core business applications—including claims and membership processing. Additional elements of the project were completed at the close of 1998—and this year, the company will conduct a final "dress rehearsal" test to verify that all systems continue to communicate with each other and with third parties.

What does "compliant" mean? According to the experts at BCBSM, a piece of equipment is Year 2000 compliant if it can operate normally before, during, and after midnight on December 31, 1999 without user intervention.

Computer systems aren't the only devices that may cause trouble. "It's everything that has a clock in it," says Nicholas Lekas, MD, a physician with the Oakwood Healthcare System in Dearborn, which has been working on the Y2K issue for the past two years. Doctor Lekas, who also serves on MSMS' Technology Committee, adds that these kinds of devices all have the potential to fall apart next year. "Every one of these items has to be assessed and we have to determine whether it is in compliance." These items can include automated sprinkler systems, telephone systems, faxes, copiers, fire-control systems, heating and ventilating systems, timepunch clocks, mailing equipment, security systems, elevators, copiers, radar systems, medical devices, health labs, traffic lights—the list goes on and on.

On its Web site, the State of Michigan Year 2000 Project Office, which is overseen by the Department of Management and Budget, calls the problem "the single most significant challenge ever encountered by the State of Michigan Information Technology community. With 35 years of design and coding standards that did not include any indication of century,

#### Y2K Resources

With more than 2 million web sites devoted to this problem, you should have no trouble finding what you need to guide you through the Y2K maze. The following list is just a starting point. All offer a tremendous amount of information and provide links to thousands of other related sites.

#### Internet Sites

www.year2000.com www.y2K.com bog.frb.fed.us/y2K (Federal site) www.ama-assn.ora www.RX2000.org www.y2Knews.com www.sba.gov (the Small Business Administration's site) www.y2K.gov (President's Council on Year 2000 Conversion site) www.state.mi.us/dmb/year2000 (State of Michigan Y2K site)

the problem is enormous. Fixing the problem is something that all organizations must do to survive. The problem is universal, pervasive, and relentless. It applies to every organization, and will not go away by itself." And, to show how big a problem this Y2K "bug" really is, the State of Michigan has estimated it to take, in total, more than one million hours of effort to make its network of systems compliant.

Like most hospitals, the Oakwood Healthcare System also has already begun its preparations. "We've been talking about the Y2K problem for awhile," says Doctor Lekas, who practices within the Oakwood system. "Oakwood actually has a plan and a budget and a consulting firm to help them out, and they've created these mission-critical definitions. High

risk is any equipment or system failures that will result in a serious health hazard to the patient or a shut-down of the operations that a service line or department provides; medium risk is equipment or systems failure that, while significant, would not pose an immediate harm to a patient. And low risk is any system whose failure or malfunction would cause significant patient and business inconveniences."

#### **Updates or New Equipment**

The division of Human Pathology at Michigan State University's Department of Human Medicine is replacing its current system with one that is Y2K compliant. "In our case, it simply requires adding some positions to other network programs we already have, so it really isn't that expensive at all," says David Rovner, MD, interim director of Human Pathology at MSU. Doctor Rovner, who also serves as assistant to the Dean for Technology and on MSMS' Technology Committee, says it's difficult to assess the size of the problem. "You can find people who are in the know, who are writing articles and saying it's no big deal. Then

there are people saying it is an impossible task and everything is going to crash. The answer lies obviously between the two extremes."

A potentially messy side issue is how to determine whether your vendors are Y2K compliant, or at least if they are working toward that goal. For physicians who rely on outside billing services for instance, it's imperative that they find out now where their vendors stand.

How do you do that? Just ask. "Is the device Y2K compliant? If it isn't, can they make it compliant?" says Doctor Lekas. "There are some vendors of small things that I believe are probably going to go out of business because it's not worth it to them. They can't replace all the devices they have in the market place and they probably don't have the capability of sending out technical personnel to fix these things."

What is the cost of all of this? Some estimates have placed the cost of updating computers for all U.S. companies at \$300 billion: \$600 billion for businesses worldwide. But Kevin Lutz says it's a bit harder to determine on an individual basis. "You can't put a cost on it because it varies from practice to practice," says

#### More Y2K Resources

Tired of sitting in front of your computer screen? Many books on this topic have also been published.

Managing 00: Surviving the Year 2000 Computing Crisis; by Peter DeJager and Richard Bergeon; John Wiley & Sons.

Software Quality—Analysis and Guidelines for Success; by Capers Jones; International Thomson Computer Press, Boston, MA.

The Year 2000 Software Problem: Quantifying the Costs and Assessing the Consequences; by Capers Jones; Addison Wesley, Reading, MA.

Year 2000 Software Crisis Solutions for IBM Legacy Systems; by Keith Jones; International Thomson Computer Press.

Solving the year 2000 Problem; edited by Leon Kappelman; International Thomson Computer Press.



Lutz. "It depends on your current state of technology, it depends on how automated you are to begin with, and it depends on the suppliers you happen to work with. One key thing to note is that technology is only one dimension of the problem. You have the dimension of suppliers you have to work with, as well as the medical field of payer-payee relationships. Obviously, if you can't receive appropriate medical supplies, it impacts your practice. But if you can't receive reimbursement for your services, that will be a significant impact as well."

The Health Care and Financing Administration, which manages the nation's Medicare programs and processes nearly a billion claims for its 38 million Medicare beneficiaries each year, conducted a five-step compliance plan to prepare for the Y2K problem: awareness, assessment, renovation, testing and certification. They expected to be compliant by the end of 1998. According to its Web site, "HCFA is making every effort to make sure that its mission critical systems will work and that in the event they don't, there is a contingency plan." Specifically, HCFA says, "... Fee-for-service

providers will be able to submit Medicare claims and receive timely payment. Managed care providers will be able to process new enrollments and receive timely payments as well."

But, HCFA stresses, health care providers must make sure their own systems are compliant. "HCFA cannot plan for Y2K-related problems of hundreds of thousands of health care providers who, due to their own unique problems and circumstances, may not be able to process Medicare claims or payments. Health care providers, and not HCFA, must be responsible for seeing that these systems are not affected by millennium problems."

#### Advice from the Experts

Kevin Lutz says communication is key. "Talk to your vendor, find out whether they have adequate plans to address the year 2000 issue. If you have any concerns, seek an alternative vendor, and establish a relationship with that vendor prior to the year 2000."

Okay, so now you're terrified the bottom will drop out when the clock strikes twelve on New Year's Eve, 1999. Relax—there is plenty you can Talk to your vendor, find out whether they have adequate plans to address the year 2000 issue.

-Kevin Lutz, VP and chief of technology, AMA

Year 2000: Best Practices for Y2K Millennium Computing; edited by Dr. Dick Lefkon; Mainframe Special Interest Group (SIG) of the Association of Information Technologies (AITP); NY, NY.

The Year 2000 Problem Solver: A Five-Step Disaster Prevention Plan; by Bryce Ragland; McGraw Hill.

The Year 2000 Planning Guide; by Brian Robbins and Dr. Howard Rubin; Rubin Systems, Inc.; Pound Ridge, NY.

The Year 2000 Software Systems Crisis: Challenge of the Century; by William Ulrich and Ian S. Haves: Prentice Hall, Yourdon Press.

How to 2000: A Proven Comprehensive Year 2000 Methodology; Raytheon E-Systems; IDG Books Worldwide. (Includes CD-ROM.)

Failure Is Not An Option: Declaring War on the Year 2000 Problem; by Michael P. Harden; Century Technology Services.

Y2K: It's Already Too Late; by Joson Kelly; Jason Kelly Press.

"In order to prepare, we [MSMS] have contacted each vendor responsible for these different and possibly affected products..."

-Bill DeCourcy, interim manager of Computer Operations, **MSMS** 

still do, starting right now, to make sure your life stays in tact.

An excellent source of information is as close as your fingertips. The internet, which should remain unaffected by the Y2K bug, offers more than two million sites devoted entirely to the year 2000 problem. A great lift-off point for the health care community is one aptly titled, "www.RX2000.org," which serves as a primer for getting physicians prepared for the millennium. Y2K software programs are also available to help guide you, and professional associations have developing educational seminars for its members.

"The AMA is addressing the year 2000 issue on several different fronts," says Lutz. "We are addressing it by producing educational materials for physicians through our Web site (www.ama-assn.org), we are hosting seminars to address all the various aspects of the year 2000 problem—both the impact on the business, the impact from a legal perspective, the impact just from the pure technology of it, and the patient safety side."

#### Addressing the Issues Locally

Bill DeCourcy, interim manager of Computer Operations for MSMS, says MSMS has conducted a complete audit of every system they believe could be affected by the Y2K problem from computers, to elevators to phone systems. "In order to prepare, we have contacted each vendor responsible for these different and possibly affected products and asked them to provide us with statements that they're year 2000 compliant." DeCourcy says MSMS has also addressed external systems on which the organization relies, making sure they are Y2K compliant as well. An education effort is also in place.

"As part of MSMS's strategic planning for the year 2000 bug, we will, through our Medical Informatics Institute, provide education seminars throughout 1999 that will concentrate on informing physicians as to the extent of the year 2000 dilemma, how it may affect their practices, and what some solutions are." DeCourcy adds that MSMS is working closely with the AMA on this issue. "They have a resource center both through their internet page, and some published materials, that we will be promoting and distributing to our membership.

#### Where to Start

Experts suggest business owners conduct a thorough inventory of all electronic equipment. After that, determine which devices are mission critical, and how to make them compliant. At this point, you may not be able to address everything by the year 2000—so identify those most important to the operation of the business, and deal with those first.

Another aspect of the Y2K problem is the potential for lawsuits, although these are directed more toward larger corporations—such as software or manufacturing companies—who, if they falter when the millennium hits, could be susceptible. Y2K insurance is available, but expensive. According to a recent article in the Denver Business Journal, a \$200 million policy costs \$20 million and a company must prove Y2K compliance to get the policy in the first place. Many companies have liability insurance to help protect against third party lawsuitshowever, these policies may or may not cover Y2K-related losses.

#### **Avoiding Legal Pitfalls**

To help keep lawsuits at bay, and protect conscientious business owners, President Clinton last fall signed a "good Samaritan" bill—called the "Year 2000 Information and Readiness Disclosure Act, S2392"—that protects people from being sued over Y2K information they disclose voluntarily. The bill creates an antitrust exemption for businesses, governments and other organizations that want to share their Y2K information.

President Clinton's statement reads in part,

Did you know . . . ?

President Clinton signed the Year 2000 Information and Readiness Disclosure Act. It is intended to promote the free disclosure and exchange of information related to Y2K readiness. The act is important to physicians and other health care organizations that are trying to identify any computerized equipment and devices that will fail because of the inability to recognize year 2000 dates. Protections that are provided by this legislation are expected to encourage more timely disclosure about Y2K compliance. The text of the act is available through the Library of Congress Web site: thomas.loc.gov/home/ thomas2.html.

"Many organizations have been reluctant to share valuable information about their experiences in dealing with the Y2K problem or the status of their Y2K efforts for fear of lawsuits. The Act's limited liability protections will promote and encourage greater information sharing about both experiences and solutions, which will significantly enhance public and private sector efforts to prepare the Nation's computer systems for the new millennium. However the bill will not affect liability that may arise from Y2K failures of systems or devices."

The safest way to avoid litigation is to make sure all equipment is Y2K compliant in time. If you have any reason to believe it isn't compliant, find another way to provide that service.

What about personal computers? Like most everyone else, many physicians own at least one. How will these be affected by Y2K? Since it is unlikely that any two PC's have the same collection of software and hardware, Y2K will mean something different for everyone. Most PCs built within the last two or three years are Y2K compliant, but if you aren't sure, check with the manufacturer. Good news for MAC users-Macintosh systems will recognize the correct date and time until February 6, 2040. To test your software, check with the manufacturer of each application; they can tell you if their product is Y2K compliant.

For small businesses, such as group or individual medical practices, the Small Business Administration has developed an online virtual classroom to help you deal with this problem. It's part of the effort organized by the President's Council on the Y2K Conversion. Since experts report that many small businesses are lagging



in their attention to the Y2K issue, this news is welcome. The SBA's interactive program has both audio and video guides and includes a self-test quiz.

Dispelling the Myths

So, what about those Y2K myths anyway? A recent USA Today report on the situation tried to lay them to rest: "No, planes will not fall from the sky. What seems more likely is that systems run by the Federal Aviation Administration and services at smaller airports may encounter problems, creating a ripple effect that will disrupt schedules. Automatic teller machines will work. There have been so many reports of potential failures that banks have made a point of making sure they will operate. Only eight percent of potential computer failures will happen at the stroke of midnight on January 1, 2000. The rest could occur over the following two years. Few VCRs care what year it is. And credit cards with expiration dates in the year 2000 or beyond have created problems, but those difficulties are being resolved."

For those who have already been working toward Y2K compliance, congratulations. For the rest of you, roll up your sleeves and let the internet be your guide to a (relatively) headache free happy new year.

The author is an Okemos-based freelance writer.

#### MSMS Plans Y2K Courses for **Physicians**

Please contact Bill DeCourcy at MSMS at (517) 336-7575 or wdecourcy@msms.ora for information regarding Y2K courses throughout the state.

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### The Business of Medicine:

Physicians Head Back to School

#### By Lisa Weatherford

Medical career is not for the faint of heart. The education alone is grueling and most practicing physicians agree, medicine is a lifestyle, not a job. But for many, a medical career is also a company. And running that company well requires education in business, an area few doctors would have considered necessary just a few years ago.

Joseph Weiss, MD, a rheumatologist in private practice, realized that what he didn't know about his business finances could hurt him. From his office books to capitation to personal investments, he felt he lacked the wisdom to make sound financial decisions. "I am a physician. I never learned accounting," he acknowledges. "I also am in solo practice so the decisions I make are intertwined. I wanted to learn how accounting applies to the medical decisions I have to make. I wanted to know if there were financial alternatives that I wasn't aware of."

#### **Putting a New Foot Forward**

So after 37 years in medicine, Doctor Weiss set a new course. His first step was to take a "mini-MBA" program sponsored by the Wayne County Medical Society and provided through Madonna University's School of Business. The 12-week program provides a look at what business is all about, and what a Master of Business Administration (MBA) degree will entail.

After gaining a level of appreciation for both business and the MBA degree, Doctor Weiss decided to undertake a second interim measure. Since November he has attended another nocredit program providing a more in-depth level of business knowledge. This program is through Johns Hopkins University and is a "big deal" according to Doctor Weiss. "It is a 40-week course with four 10-week studies in managed

care, accounting for medical decision making, managerial finance, and leadership. What I learn in these classes will tell me whether or not I want to go for my MBA."

#### **Knowledge** is Power

Another route was taken by Lyle Victor, MD, a specialist in pulmonary and sleep medicine at Dearborn's

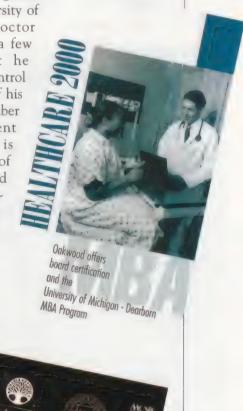
Oakwood Hospital. A soon-to-be MBA graduate of the University of Michigan, Doctor Victor decided a few years ago that he wanted to gain control of the business of his career. "The number one reason I went back to school is that I was tired of being manhandled by money managers. So now I talk their language. Now I know they can't 'beat the market' with my pension plan. Now I know nobody can

ket."
But he acknowledges the price for his new degree will be

beat the mar-

considered high by most.

"Yes there is a price to pay. You work and you go to school and that is all you do for



four years. I didn't even tell anyone when I started. But I do think it is easier when you are older."

In spite of it all, however, Doctor Victor began early on to appreciate the potential good a business education could provide to health care givers and receivers alike. That is, that physicians who are trained in business have a unique gift to offer the health care system. "I believe physicians can manage the health care system. I see a revolution here," he says. "I think physicians are recognizing that business is an important component of what they do. I see it as a combination of equity—filling the needs of the patient, and financial—how are we going to pay for it?"

#### Popular Business Programs for Physicians Oakwood/UM-Dearborn Scholars Program

Contact your residency program coordinator: Diagnostic Radiology - (313) 593-7302 Family Practice - (313) 593-7798 Internal Medicine - (313) 593-7796 Ob/Gyn - (313) 593-7819 Transitional Residency –(313) 593-8435

#### The University of Michigan Dearborn

Contact the School of Management: (313) 593-5460

#### **University of Michigan**

Health and Policy Management Master's Program: (734) 764-1817

#### **Madonna University Medical and Dental**

Practice Administration Executive Fellows Program Contact Graduate Studies: (734) 432-5667

#### **Johns Hopkins University**

Contact the Caliber Learning Network: (410) 843-1000

#### **Michigan State University**

Contact the Weekend MBA Program in Integrative Management: (517) 355-7603 or (800) PIM-MSU-1

#### **Vision Takes Shape**

With that in mind, Doctor Victor launched what he considers his vision for the future of health care. As program director of Transitional Year Residency at Oakwood Healthcare Systems, he approached the University of Michigan Dearborn with a plan to provide a few first-year residents with the opportunity to begin the university's MBA program. Soon to begin its second class, the Oakwood MBA Scholars program now provides two residents a fully funded chance to pursue an MBA while completing their residency. Special considerations for the residents include one class per year for the first year and an extra year to complete the program.

Obviously, pursuing a masters degree during residency takes a special kind of person. And that, says Doctor Victor, is exactly the kind of people he wants to help. "The selection committee looks for the most outstanding Oakwood residents. We look at board scores and GMAT scores and we try to get an idea of how well an individual will do. We are asking people to excel in both medicine and management. Stamina and motivation plus intelligence are prerequisites."

#### What the Future May Bring

It is just this enterprising spirit that both Doctors Victor and Weiss believe exemplifies what the future might hold. As more physicians realize the need for business knowledge, more programs are becoming available not only for MBAs, but for MBAs tailored to the health care provider. At Madonna University, a full fouryear program is offered for both medical and dental practitioners, and Johns Hopkins University offers the same for physicians.

At the University of Michigan Dearborn, Iulie Dzekian, assistant dean and director of the School of Management Graduate Programs, says they soon will offer a not-for-credit 10-week "sampler" for health care professionals to "provide exposure to critical issues from a health care provider's perspective." This she says is "just the tip of the iceberg" adding that the university will continue to assess the needs of the communities it serves as it looks at future program changes.

The U of M also offers a traditional MBA program as do several other Michigan universities. Michigan State University also offers a weekend MBA designed to accommodate the working professional.

The author is an East Lansing-based freelance

#### MSMS Resources for the Business Side of Practice

For information on the following services provided by MSMS, please call the MSMS contact listed below at (517) 337-1351:

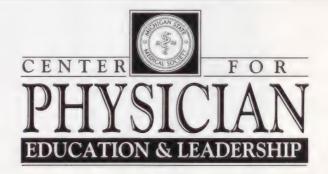
- Contracting Checklist—Charles Cuzydlo, JD
- · Case Study on Mergers—Tom Wolff
- Hospital Financial Data in Brief—F.B. "Tom" Plasman
- The MSMS Evaluation of Michigan Health Plans—Julie Lester
- •MD Data—Laura Campbell

For more information on MSMS courses designed to enhance the business side of practice, see the ad below, or contact the Center for Physician Education and Leadership.

#### SAVE THESE DATES!

Wednesday, April 28, 1999 8:00 a.m.-4:00 p.m. Amway Grand Grand Rapids

Wednesday, May 12, 1999 8:00 a.m.-4:00 p.m. Dearborn Inn Dearborn



#### Health Care Negotiations and Conflict Resolution Training

MSMS kicks off its Physician Leadership Program with two day-long conferences on negotiations and health care. Each one-day program conducted by Leonard Marcus, PhD, Director of the Program for Health Care Negotiation and Conflict Resolution at the Harvard School of Public Health, will examine negotiating and problem solving models in health care.

For more information please call Mary Jensen, education coordinator at MSMS Center for Physician Education and Leadership at (517) 336-5706 or mjensen2@msms.org.

MSMS also offers a wide variety of educational seminars on corporate compliance, E&M documentation, risk management, and educational opportunities for office staff. Please contact the Center for Physician Education and Leadership at (517) 336-7581 for a 1999 education calendar.

### Physicians Bring GI Diagnosis, Procedures to Rural Mexico

Doctors Veldman and Wiedemer on a Medical Mission

By Gregory Brusstar

ith lofty goals and logistical challenges from the start, it was a medical mission that could have foundered, by all accounts. Lead by Lansing bediatrician Jerold Veldman, MD, a group of church-sponsored volunteers met short deadlines, overcame financial obstacles, and jumped through senseless, but necessary, bureaucratic hoops at the Customs Office. But with ardor and determination. they succeeded in bringing a vital new service to a hospital in rural Mexico.

Harkening back to his volunteer days near Bombay, India, Doctor Veldman offered to lead a medical mission if he could garner financial support from his church, the Interdenominational Peoples Church of East Lansing.

The Peoples Church Outreach Commission was receptive to Doctor Veldman's idea of a medical mission. Doctor Veldman then contacted the Medical Benevolence Foundation (MBF) for a list of mission opportunities.

The chief considerations were matching its medical manpower and organizational capabilities with the project. Sifting through the possibilities, one unusual project stood above the rest. It involved training hospital physicians and nurses in Mexico to perform endoscopic diagnosis and procedures. Commission member Marianne Wiedemer had a specialist in mind for the mission: her husband.

David H. Wiedemer, MD, an East Lansing gastroenterologist for 20 years, was pulled into the discussion and agreed to participate in the mission if the job were done right. For Doctor Wiedemer, doing it right meant making the Mexican hospital self-sufficient. This included taking up-to-date equipment to them, training staff to competently perform the procedures and maintain the equipment, and bringing enough supplies to last several months.

"I believed it was important to leave them

with the capability to perform the procedure themselves," Doctor Wiedemer said. "When it's possible, a hand-up is preferable to a hand-out."

The wheels of the project were thus set in motion in December. 1997. Alfredo Yanez Lobato, MD. the director of the Hospital de la Amistad in Ometepec (about 125 miles east of Acapulco), was informed that his request had been met. This 35-bed rural hospital serves 350 patients weekly-

primarily indigents—from the town of 11,500 and its surrounding mountain population. Six physicians and 14 nurses staff the facility.

The people of the region are at high risk for stomach and intestinal cancer, according to the World Health Organization, making diagnosis and treatment important. No endoscopic services were available in the area, and the people are too poor to travel to Acapulco.

The date of the mission was set for the week of May 29, 1998—only six months from the project's conception. By any measure, this was a short deadline for raising an estimated \$50,000 in money and equipment.

"We wanted to step up to the challenge," said Mrs. Wiedemer, whose organizational skills were essential to the project's success. "We knew somehow we could do it. Looking back on everything we went through, it was a great leap of faith."

#### **Hurdle 1: Fund Raising**

Beginning in March, 1998, funds were solicited from the church congregation, Ingham County Medical Society members, and the Presbyterian Church USA. Physician church members provided the essential core of funds that other groups, including county and state medical society physicians, matched. In a mere four months, enough money and equipment was

"I believed it was important to leave them with the capability to perform the procedure themselves."

> -David H. Wiedemer, MD

Peoples Church Medical Mission Team. (top row, left to right) Jerold Veldman, MD; David Wiedemer, MD; (second row from top, left to right) Prof. Peter Schroeder; Tom Ammann: Lois Veldman: (middle row, left to right) Mary Ducker, RN; Marianne Wiedemer; Gwyneth Schroeder, MD; (bottom row, left to right) Mark Ducker; Juan Posada: Steve Summerschield.

donated to complete the mission goal! Cash donations about \$20,000 and equipment donations from Ingham Regional Medical Center and Sparrow Health System were estimated at \$32,000. The donated funds were quickly converted into the bits and pieces of a complete recycled endoscopy unit, including three gastroscopes and three colonoscopes.

#### **Hurdle 2: The People**

As the planning continued, Doctor Wiedemer enlisted Mary Ducker, RN, an endoscopy nurse from Sparrow Hospital, to be the nurse trainer in Mexico. Mary also helped him list and select all the equipment and supplies needed to set up an endoscopy unit.

"Mary was an essential part of the team," Doctor Wiedemer said. "The best decision I made was to recruit her and follow her suggestions."

Since the mission would involve training a hospital staff that spoke little English, interpreters were crucial. The key was to find someone with the ability to translate medical and technical terms. Juan Posada, a student at Michigan State University majoring in Social Work, was chosen for the task. Two more team members were fluent in Spanish.

In addition, several non-medical team members would perform badly needed maintenance work in the hospital, which was damaged in a 1996 earthquake.

In all, the medical mission consisted of 13 people led by Rev. David Jenkens, a regional director of the MBF, which sponsored the mission through the Presbyterian Church USA. They would be housed in a nurses' dormitory on the hospital grounds, with meals provided.



#### **Hurdle 3: Customs**

The group had been advised to carry the medical equipment—packed into 17 plastic footlockers—into Mexico as baggage on the flight down. This low-cost option, chosen to avoid the risk of theft, also had its own risks: Mexico's Customs Office is notoriously bureaucratic and unpredictable. To obtain the necessary approvals and proper documentation, the group benefited from the hard work and tenacity of Rep. Debbie Stabenow and her staff, who identified contacts and paved the way.

Even after all the Customs requirements had been confirmed. Doctor Veldman received a call from Mexico the very day before their flight to Mexico.

All 17 footlockers of equipment and supplies were impounded by Customs and required a



Doctor Wiedemer (far left) guides Doctor Yanez (center, with instrument) during an endoscopy procedure at the La Amistad Mission Hospital. Nurse Mary Ducker (far right) shares patient care with Juanita the hospital's nursing supervisor. Juan Posada translates for both teaching exchanges.

change in plans and documents (and an import duty).

To their relief, by Monday, the Acupulco Customs Office released all 17 containers complete and intact.

"The exuberance we felt when we got the equipment to Ometepec was unbelievable," Mrs. Wiedemer said. "It was a victory that brought all of us together. We didn't have a common language bond, but we had a bond of trust and commitment that wouldn't have been there without the problems we experienced."

#### The Medical Mission

The endoscopy training went like clockwork. Though the hours were long each day, the physicians and nurses were quick studies and extremely thankful for the equipment and training. Doctor Wiedemer, Mary Ducker, MSU medical student Steve Summerschield, and interpreter Juan Posada worked in the operating room. A group wrote instructions on use and cleaning of the equipment that had to be translated into Spanish. Doctor Veldman organized a system to keep track of spare parts, and he also worked with the maintenance crew, repairing and painting. Doctor Yanez's wife

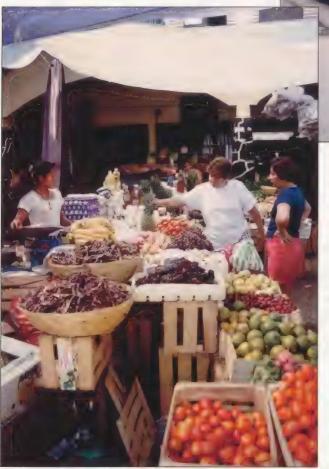
The busy La Amistad Hospital serves all who seek help. Patients pay what they can.

arranged all the meals, which got rave reviews from the missionaries.

When it was time to leave, Doctor Wiedemer had conducted 55 teaching gastroscopies, colonoscopies, and sigmoidoscopies and was satisfied that Doctor Yanez and nurse assistants could effectively perform the procedures and recognize pathology.

"It's a much different medical environment than we have here," Doctor Wiedemer commented. "Families of patients assist in their care, they sleep in the halls, on the porches, in the yard. All were grateful for the care. Dedicated staff does extremely well with limited resources."

The marketplace in Ometepec brings indian vendors from the surrounding mountain district. Americans were unusual visitors in this town, so far removed from tourist resorts.



from the mission. In his retirement, he plans to travel, visit his children, and periodically participate in medical missionary work. In fact, he and his wife, Lois, may revisit India soon. His wife was invited back to Miraj to work on a project at the medical school library.

Mrs. Wiedemer, encourages people to forge ahead with medical missions, despite formidable fundraising and planning obstacles.

"There is no recipe for planning a medical mission," she says. "People who want to do this have it within their grasp. The community will rally around them and help them succeed. God will smile on them."

The author is an Okemos-based freelance writer.

#### **Looking Backwards**

This was Doctor Wiedemer's first medical mission, but it won't be his last. He and a few others will go back to Ometepec in two years to review progress and build colonoscopy skills. He recommends the experience to other physicians.

Doctor Veldman firmly believes medical missions change people. "Everybody came back a different person," he said. "It was truly a journey of faith for us. In January, we had nothing but an idea. By the end of May, it all came together somehow." Doctor Veldman, who lives in Okemos, retired two months after returning

#### Do You Know Others Who Make a Difference?

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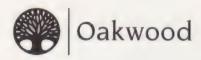


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Part Two:

### Triggers for Advance Directives

By James E. Wann, MD

dvance directives can save physicians time and ease and improve the process of making difficult medical decisions for patients. They work best when they are updated as circumstances change for patients and their families. This article will describe some "triggers" that bhysicians can use to remind themselves to encourage patients to execute advance directives and to periodically review and update them.

An earlier article in this series (December 1998, p. 50) provided details on advance directives and explained physicians' office personnel's roles in getting them signed and, using flags placed on the front of charts, keeping them updated. In a nutshell, advance directives safeguard incompetent patients' rights to accept and reject medical treatments. By selecting a surrogate decision maker or patient advocate to make medical decisions when they are unable to, patients' interests are protected and the decision-making process is simplified.

#### How are Advance Directives Helpful?

Physicians are lynchpins in using advance directives. They must first recognize how advance directives can save them time, strife, and possibly even protect them from becoming involved in lawsuits. It is to their advantage to establish a system that puts advance directives to work in their practice.

Putting advance directives to work begins with patients' understanding how they benefit from having an advance directive to protect their right to make medical decisions, how it may save them from receiving unwanted medical treatment. This important patient education can be done by having advance directive pamphlets available in the waiting room, by having a wall chart that catches their attention and gives them important information, and by office personnel showing an interest in having them complete advance directives.

#### Stressing the Importance of Advance Directives

Office staff needs to understand the importance of advance directives and have clear instructions on getting them signed, updated as circumstances change

for patients and their families, and placed in office and hospital charts and in the hands of referral physicians and institutions.

Physicians ought to review their patients' advance directives to check on the availability of surrogate decision makers, whether patients' advocates understand their values and desires. and whether specified instructions about wanted or unwanted medical therapies are sufficiently broad and/or specific. At the end of their reviews, physicians need to feel as though they understand their patients' wishes as conveved in directives.

Once they have been completed and reviewed, physicians will be prepared to use their patients' advance directives. When conditions change and patients develop new and serious conditions like cancer, hypertension, heart attack, diabetes, serious injury and/or disability, physicians ought to be triggered to review their patients' advance directives. This fulfils the old adage: "A stitch in time saves nine." That is, it prepares, in advance of crises, to smooth the

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process of making medical decisions, reducing the stress and strife of the moment. By being prepared before competency challenging events occur, physicians can help protect their patients' interests for making future decisions, and themselves from unnecessary confusion and anxiety in the decision process.

#### Adding a Personal Touch

There is also a personal trigger that physicians can use to remind themselves to review patient's advance directives. Conscientious physicians often personally identify themselves,

or a loved one, with their patients' circumstances. Identification of the self with another, along with understanding prognoses and the predictability of complications, triggers them to help their patients prepare for reasonably anticipated medical care decisions by instituting, or updating advance directives. Triggers presented by physicians' personal identification with patients can be very effective in recognizing the need to update and prepare to use advance directives.

The author is co-chair of the MSMS Committee on Bioethics.

### **Triggers for Advance Directives**

#### System for using advance directives:

#### Waiting room

- Brochures
- Wall chart

#### Office staff

- Understand importance of, and orientation to, system of using advance directives
- Clear directions on getting advance directives signed and in chart(s)
- Flags on charts
- Triggers for updating and reviewing advance directives

#### Physician review of advance directives

#### Who is surrogate decision maker or advocate?

- How is he/she contacted?
- Is advocate readily available?
- Has patient discussed values and wishes with advocate?
- Are instructions in directive vague/specific enough to be useful?
- Do I understand them, and have I discussed them with the patient?

#### What would I want for me, or a member of my family, under the circumstances the patient is in?

Review patient's advance directive

#### **February**

- 2, MSMS Center for Physician Education and Leadership presents "1999 Medicare Update." Location: MSU Erikson Hall, East Lansing, MI, REMEC teleconference sites, 1:00 p.m. 4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 9, MSMS Center for Physician Education and Leadership presents "E & M Tools, Tricks, and Helpful Hints for Surgical Specialists." Location: U of M Kiva, Ann Arbor, MI, 6:00 p.m.–9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 10, MSMS Center for Physician Education and Leadership presents "E & M Tools, Tricks, and Helpful Hints for Primary Care." Location: U of M Kiva, Ann Arbor, MI, 8:00 a.m.–11:00a.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 11, MSMS Center for Physician Education and Leadership presents "Practice Mergers." Location: Days Inn, Grand Rapids, MI, 6:00 p.m.—9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.
- 17, MSMS Center for Physician Education and Leadership presents "E & M Tools, Tricks, and Helpful Hints for Non-Surgical Specialists and Primary Care." Location: Fetzer Center, Kalamazoo, MI, 8:00 a.m.–11:00 a.m. Contact: Jennifer

Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.

- 18, MSMS Center for Physician Education and Leadership presents "E & M Tools, Tricks, and Helpful Hints for Non-Surgical Specialists and Primary Care." Location: Gateway Holiday Inn, Flint, MI, 8:00 a.m.–11:00 a.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 24, MSMS Center for Physician Education and Leadership presents "Practice Mergers." Location: Dearborn, Dearborn Inn, MI, 6:00 p.m.–9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.

#### March

- 4, MSMS CME Accreditation Committee Meeting. Location: Board Room MSMS Headquarters, East Lansing, MI, 1:30–4:30 p.m. Contact: Sarah Cressman at MSMS at (517) 336-5727 or scressman@msms.org.
- 5, "Trauma, Violence and Loss in Children—Teens: A Multicultural Perspective" Presented by Ele's Place—Speaker Ronald K. Barrett, PhD. Location: Marriott University Place, East Lansing, MI 8:00 a.m.—4:00 p.m. Contact: Ele's Place at (517) 482-1315.
- 5-6, MSMS Joint Section Meeting. Location: Ritz Carlton, Dearborn, MI. Contact: Judy Marr at MSMS at (517) 336-5744 or

jmarr@msms.org.

- 10, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing, MI, 10:00 a.m.—4:00 p.m. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.
- 11, MSMS Center for Physician Education and Leadership presents "Corporate Compliance: Fraud and Abuse." Location: U of M Kiva, Ann Arbor, MI, 6:00 p.m.—9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 16, MSMS Center for Physician Education and Leadership presents "E & M Tools, Tricks, and Helpful Hints for Surgical Specialists." Location: Dearborn Inn, Dearborn, MI, 6:00 p.m.–9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 17, MSMS Center for Physician Education and Leadership presents "E & M Tools, Tricks, and Helpful Hints for Primary Care." Location: Dearborn Inn, Dearborn, MI, 8:00 a.m.–11:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 18, 38<sup>th</sup> Annual MSMS Conference on Maternal and Perinatal Health. Location: Dearborn Inn, Dearborn, MI. Contact: Sherry Fent at MSMS at (517) 336-5730 or sfent@msms.org.

23, MSMS Center for Physician Education and Leadership presents "Corporate Compliance: Fraud and Abuse." Location: Fetzer Center. Kalamazoo, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.

24, MSMS Center for Physician **Education and Leadership presents** "Medicare + Choice." Location: Dearborn, Dearborn Inn. MI. 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.

24, MSMS CME Programming Committee Meeting. Location: MSMS Headquarters, The Atrium, East Lansing, MI, 3:00-5:30 p.m. Contact: Sarah Cressman at MSMS 336-5727 at (517) scressman@msms.org.

25, MSMS Center for Physician Education and Leadership presents "Medicare + Choice." Location: Days Inn, Grand Rapids, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.

April

7, MSMS Committee on State Legislation and Regulations. Location: MSMS Headquarters, East Lansing, MI, 2:00-5:00 p.m. Contact: Greg Aronin at MSMS at (517) 336-5739 or garonin@msms.org.

15, MSMS Center for Physician **Education and Leadership presents** "Corporate Compliance: Fraud

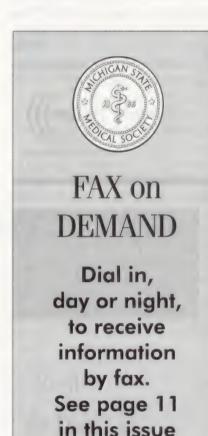
and Abuse." Location: Munson Medical Center, Traverse City, MI. 6:00-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.

21, MSMS Center for Physician Education and Leadership presents "Corporate Compliance: Fraud and Abuse." Location: Hampton Inn, Warren, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.

28, MSMS Center for Physician Education and Leadership presents "Negotiations Seminar" Location: Amway Grand, Grand Rapids, MI, 8:00 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.

30, MSMS Board of Directors Meeting. Location: Ritz Carlton Hotel, Dearborn, MI, 3:00 p.m. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.

30-5/02, MSMS House of Delegates Meeting. Location: Ritz Carlton Hotel, Dearborn, MI. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.



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Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

#### FEBRUARY 1999

4-6. Neurology for the Non-Neurologist. Location: Hyatt Regency. Cancun, Mexico. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

5-7, Arrhythmias: Interpretation, Diagnosis & Management. Location: MGM Grand, Las Vegas, NV. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

11-14, Neurology in Clinical Practice. Location: Rancho Bernardo Inn, San Diego, CA. Mayo Foundation, Rochester, Minnesota. Contact: Registrars, Mayo Foundation, Mayo School of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; fax (507) 284-0532. Approved for: 20 Category 1 credits.

12-14, Clinical Endocrinology for Primary Care Physicians. Location: Beaver Run Resort. Breckenridge, CO. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

19-21, Managing Respiratory Diseases. Location: Marriott's Casa Marina, Key West, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

22-26, Selected Topics in Internal Medicine. Location: Hapuna Beach Prince Hotel, Mauna Kea Resort, Big Island of Hawaii. Contact: Mayo Foundation, Rochester, Minnesota. Registrars, Mayo Foundation, Mayo School of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; fax (507) 284-0532. Approved for: 27 Category 1 credits.

25-27, Dermatology for the Non-Dermatologist. Location: Atlantis Paradise Resort, Bahamas. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

26-28, Coronary Heart Disease Update. Location: Hilton Tapatio Cliffs, Phoenix, AZ.. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

#### **MARCH 1999**

3-7, Radiology in the Desert: Practical Aspects of Radiology and Imaging. Location: Marriott's Camelback Inn, Scottsdale, AZ. Contact: Iovce Robertson, registrar. Department of Medical Education Professions, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: TBA.

8-12, Tutorials in Diagnostic Radiology. Location: Keystone Resort, Keystone, CO. Contact: Mayo Foundation, Rochester, Minnesota. Registrars, Mayo Foundation, Mayo School of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; fax (507) 284-0532. Approved for: 27 Category 1 credits.

12-14, Dermatology for the Non-Dermatologist. Location: Riviera Hotel & Casino, Las Vegas, NV. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

18, 38th Annual MSMS Conference on Maternal and Perinatal Health. Location: Dearborn Inn. Dearborn, MI. Contact: Sherry Fent at MSMS at (517) 336-5730 or sfent@msms.org. Approved for: 6.5 Category 1 credits.

24-26, Coronary Heart Disease Update. Location: Westin Maui Resort, Maui, HI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits. Joint Course with Arrhythmias: Interpretation, Diagnosis, and Management.

25-27, Neurology for the Non-Neurologist. Location: Grand Beach Resort, St. Thomas, USVI.

Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court. Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

25-27, Clinical Endocrinology for Primary Care Physicians. Location: Marriott's Beach Resort, Grand Cayman. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO

80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

26-28, Managing Respiratory Diseases. Location: Buena Vista Palace, Orlando, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

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#### NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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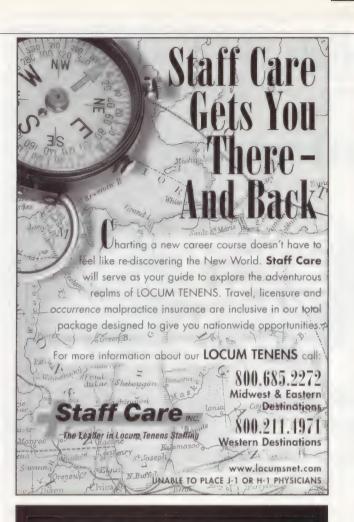


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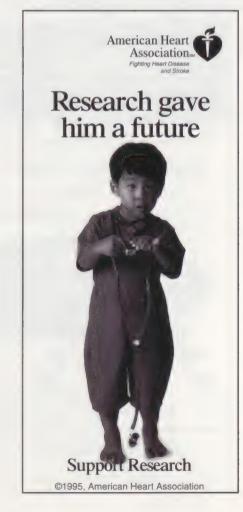
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#### Could the Sky Be Falling?

By Cathy O. Blight, MD MSMS President



**"T**he sky is falling, the sky is falling." Who among us doesn't remember that panicked cry of Chicken Little from either having had the fairy tale read to us as children or reading it to our children? And, how often has a subtle but knowing smile passed our lips when we see the person wearing the placard "the end is near?" Now, there is Y2K.

We are fast approaching the start of a new millennium, with all its hopes and promises. Will this changing of the calendar be the grand entry of the technology of tomorrow or will we all wish we were back in the sixties, when all things seemed to work?

#### Preparing for the Future

Almost every publication one reads today has some commentary on the Y2K problem. Trees are slaughtered so mailboxes can be filled with brochures offering to "fix" your Y2K problems for you, for a price.

Will the world really grind to a halt because someone made a "quick fix" when computers were first exerting their influence in our lives? This quick fix probably resulted because the millennium was so far away that using two ending digits instead of three or four, could hasten their use and acceptance in our lives. And, of course, there was a lot of time to remedy the problem.

Like so many other things, we didn't sense the urgency in developing meaningful solutions until "the end was near." What will happen at this time next year? Will the "sky fall?"

#### Tips for a Smooth Transition

In this issue of Michigan Medicine, the Y2K problem and advice on how to navigate this changing time are discussed at length. There are tips on how to prepare yourself, your practice, your family, and personal life. Implications beyond January 1, 2000 also are discussed. Besides just that date, there are other issues surfacing within the next 24 months that promise to rival the Y2K prob-

66 We are fast approaching the start of a new millennium. with all its hopes and promises. Will this changing of the calendar be the grand entry of the technology of tomorrow or will we all wish we were back in the sixties, when all things seemed to work? 99

lems. For a while, at least, the machines that are supposed to enhance our lives may well make them miserable.

Are the problems of Y2K really so different than other problems in our lives? To be sure, for a while, the consequences promise to be monumental, but eventually things get worked out. In other areas of our lives, how many times have we opted for the "quick fix" only to realize unintended consequences days,

months, or years later? Medicine certainly is replete with examples.

When antibiotics were first used. Those "magic bullets" promised to wipe infectious diseases off the face of the earth. Now, these resilient bugs are winning, again, and our armamentarium is challenged every day. Isn't part of this challenge due to our acquiescence to patient demands for an antibiotic when we know their problem is probably viral and wouldn't be helped by an antibiotic, anyway?

#### Looking for a Quick Fix?

Collectively, we, as a profession, are sometimes pushed into "quick fix" solutions for a problem that needs more serious consideration. The "drive-thru" deliveries and mastectomies come to mind. Legislating against the "disease of the month" is often simpler than engaging our legislators, business colleagues, and insurance benefits in the era of cost consciousness.

None of us are immune from the "quick fix" mentality. It seems almost human nature. But, we can't use it as an excuse. When things are not working as we planned, we must endeavor to take a step back, reassess the situation, then try another method. We must continue to bring our best thoughts and actions to all phases of our lives.

As for Y2K, I have great confidence that the best minds in the computer world are dealing with this right now. But for me, come next January, I plan to have on hand some cash and lots of pencils and paper, just in case.

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Benjamin Disraeli, English statesman

### "People do not change with the times, they change the times."

P.K. Shaw, Author

### "We need change to go forward or we fall behind. Standing still is not an option."

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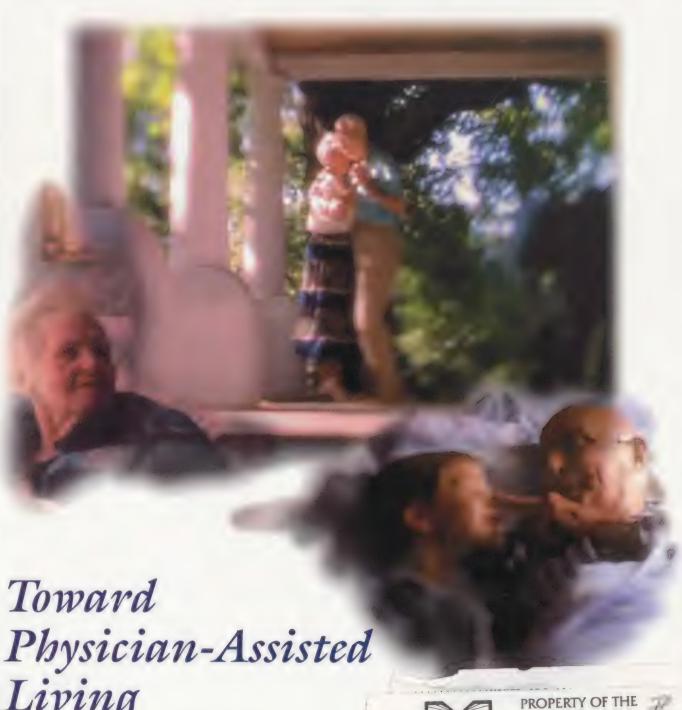
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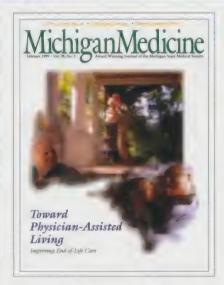
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#### COVER STORY



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#### Toward Physician-Assisted Living Improving End-of-Life Care

Through the debate and defeat of Proposal B last fall, Michigan's citizens sent this message: While assisted suicide is not the answer, we want and need the medical community to improve the care we receive at the end of life. MSMS' Task Force on End-of-Life Care has responded with an ambitious agenda, and Michigan physicians are taking the leadership role in meeting medicine's duty and our patients' mandate.

By Gregory Brusstar

#### FEATURES

#### REIMBURSEMENT BRIEF

#### Billing Medicare for Incident-To Services

Medicare made a lot of changes in 1998 that affected the types of services that Physician Assistants (PA) and Nurse Practitioners (NP) could provide and be reimbursed for. Many physicians and billers are left with unanswered questions.

By Kim Crawford

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#### **Kudos for Allegan Physician**

I have experienced an outstanding physician and medical office staff who are dedicated to their profession, as well as to the public at large. They are Marcus Blass, MD, a general surgeon, and the staff at the Allegan Medical Clinic in Allegan, MI. I am hoping that the Michigan State Medical Society might recognize them in some way. That is why I am writing.

Doctor Blass went well beyond the call of duty in regard to a patient by the name of Evelyn Morrison my mother. In the fall of 1998, she was diagnosed with lung cancer that had spread into the liver (stage 4 lung cancer), giving her 3-12 months to live. As surgery was no longer an option, Doctor Blass had no alternative but to refer Evelyn to an excellent oncologist in her own regard, Marcia Liepman, MD. This resulted in Doctor Blass being removed from her case.

However, the entire time that Evelvn had been seeing the oncologist, Doctor Blass had been in constant contact with her and my family. He made numerous phone calls to my home during the evening hours inquiring about her progress, and even went as far as to ask us to stop by his office during our visits with the oncologist so that we could keep him informed of Evelyn's progress.

My family also made the decision to contact a doctor at the Rush Cancer Institute in Chicago for a second opinion. At which time, Doctor Blass and his staff did everything they could to see that we had the appropriate paperwork and x-rays we needed to take with us. He recommended this and made the necessary arrangements so that Evelyn would not have to go through any unnecessary testing. He encouraged us to go, giving us his blessing. The diagnosis from Rush was identical to the Allegan doctors; however, the course of action was much harsher. Therefore, because of the dedicated treatment we received with the Allegan Medical Clinic, we returned to Allegan.

My mother commented that she had never in her 79 years experienced such wonderful treatment from a physician. Evelyn and I have been so touched and blessed by the "bedside manner" we received from Doctor Blass. His wisdom to us continued to keep my mother and her family focused positively in the midst of devastating news. He and his office staff have comforted us, with a personal touch, well beyond what we will ever be able to share in words. We want his efforts, and the efforts of his staff, on our behalf, recognized and praised.

Today, we continually hear such negative statements made in regard to the Medical Profession. For a change, we need to focus on the positive, and give thanks where thanks is due. I am in hopes that we can shed a little light in the middle of such darkness. The people of Allegan County need to know where they can go to receive such treatment. They should be very proud to have such professionals representing them in their time of need.

Sincerely, Christine V. Truer Grand Iunction, MI

Editor's Note: When obtaining permission to print this letter, Mrs. Truer informed us that Evelyn Morrison passed away on December 2, 1998. Her family is grateful for the care she received from Doctor Blass and his office staff, and she requested that this letter remain in the magazine as a tribute to her mother and Doctor Blass.

#### **Comment Line**

The editorial staff at Michigan Medicine is interested in your opinion on our stories. Please share your thoughts and ideas with us via telephone, fax, email, or mail. Send comments to:

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### **Employee Health** Insurance/Discrimination Rules

By Richard D. Weber, JD

MSMS legal counsel



Question: I am a stockholder in a medical professional corporation. If we provide health insurance to employees, is it true that all employees must be given the same health insurance benefits?

#### Answer:

My partner, Curtis J. DeRoo, JD, specializes in this field. He has provided the following answer:

Health insurance discrimination laws depend upon whether the plan is self-insured or provided through insurance. A self-insured plan is a plan under which the employer assumes the risk of loss. A fully insured plan is a plan under which the employer pays premiums and the insurance company assumes the risk of loss. Generally speaking, only large employers have self-insured health benefits as only they can afford to underwrite the risk associated with medical conditions for employees. Typically, a medical practice is not large enough to be involved in this type of self-insurance. A medical practice might provide some type of medical reimbursement coverage, such as a specified amount per employee to reimburse out-of-pocket costs like deductibles, prescription drugs, and co-pays. Such a reimbursement program would be considered self-insurance, and subject to the self-insurance rules.

#### Self-Insurance

Self-insurance plans are subject to strict discrimination rules. These rules are similar to pension type coverage rules, in that nearly all employees need to be covered. The

exact parameters are not discussed in this article for the reason that a self-insured medical practice would be rare. Like pension plans, the dividing line is \$80,000 of salary or income. If discrimination is found under a self-insurance program, the benefits received are considered discriminatory and deemed to be income to the owners or highly paid employees who receive the benefits. They are taxable income and no longer tax free health benefits.

#### Insured Plans

Any traditional insurance program, such as Blue Cross Blue Shield of Michigan, which is administered as a group plan by Physician Service Group, a MSMS related corporation, would be a fully insured program. An attempt was made to place discrimination requirements on insured health plans in 1989, under Internal Revenue Code Section 89. This proposal met with significant resistance by small business and the provision was ultimately repealed before its effective date. As a result, there are no discrimination rules as long as the program is fully insured. In this instance, therefore, a medical professional corporation or other entity is not required to provide the same health insurance benefits to all employees. Physicians can have a

different (and better) health insurance program than

non-physician employees, and it is perfectly legal as long as it is fully insured. Physicians can have a health insurance program and provide no insurance for their nonphysician employees, or provide some with insurance, and some without insurance. The limiting factor will be the coverage rules of the insurance carrier rather than any tax discrimination laws.

#### **Mixed Plans**

A medical practice can offer a mixture of programs, such as a fully insured program plus a medical reimbursement plan. The medical practice is not subject to discrimination under the health insurance side of the program. However, the medical practice is subject to the discrimination rules under the selfinsured portion of the program, namely the medical reimbursement side.

#### Cafeteria Plans

A cafeteria plan exists when an employee has a choice between cash and one or more benefits. A medical practice may allow an employee to choose a higher salary or a reduced salary plus health insurance at the employer's expense. This type of option is technically a cafeteria plan and cafeteria plans are subject to all of the discrimination rules. In short, all the employees need to be given the same choices and legal

Editor's note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Kristen Lare, managing editor, P.O. Box 950, East Lansing, MI 48826-0950.

requirements must be met. A cafeteria plan requires a written plan, election forms, and separate tax returns (Form 5500).

#### Tax Considerations

For insured plans, the employer may deduct the premiums and the benefits are not taxable to the employees, regardless of whether discrimination exists. The rule is the same for self-insured plans if they are non-discriminatory; but for selfinsured plans that are discriminatory, these tax benefits are limited. If a self-insured plan is discriminatory, the benefits are still tax free to the non-owner or non-highly paid employees, and the employer may deduct the cost of the benefit to these employees; however, the employer may not deduct the cost applicable to the owner or highly paid employees, and those benefits are taxable to the owner or highly paid employees. These rules apply regardless of whether the employer is a professional corporation, partnership, limited liability company, or subchapter S corporation, except the level at which the deduction is taken varies. The costs for non-owner or non-highly paid employees is always deducted at the entity level. If the employer is a professional corporation, the deduction for owners or highly paid employees is at the entity level. If the employer is one of the other business organizations, it is a pass through entity for tax purposes and the deduction for owners or highly paid employees is at the partner, member or subchapter S shareholder level.

The author is senior partner with Kerr, Russell, & Weber, Detroit, USAT

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The MSMS HIV/AIDS Speakers Bureau is a resource comprised of over 150 individuals available to speak to groups free of charge on a variety of HIV/AIDS-related issues. Available speakers include doctors, nurses, social workers, attorneys, infection control practitioners, and people living with HIV/AIDS. The HIV/AIDS Speakers Bureau is part of the MSMS AIDS Provider Education Project.

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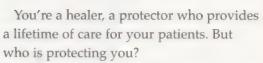
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# **Billing Medicare for** Incident-To Services

By Kim Crawford

edicare made a lot of changes in 1998 that affected the types of services that Physician Assistants (PA) and Nurse Practitioners (NP) could provide and be reimbursed for. What has not changed is HCFA's definition of the "incident-to" provision for billing services. Many physicians and billers are left with unanswered questions. What is incident-to? Who can provide services under incidentto? What level of E & M service can be billed as incident-to? How will PAs and NPs be reimbursed for incident-to services?

#### What is Incident-To?

The best starting point may be to look at HCFA's definition, which many third-party carriers have adopted. Medicare defines "incidentto" services or supplies as:

that are furnished as integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

What this translates to is that even though the physician does not see the patient during an office visit, the service can be provided and documented by an employee of the physician, under direct supervision of the physician. The physician must be in the office or the office space while the employee is performing the service in order to meet the direct-supervision criteria. The physician may be engaged in other duties, such as caring for another patient, dictating medical records, or reviewing x-rays. In this scenario, the bill should be sent out, using the supervising physician's name, and be paid at the physician's allowable from the Medicare Fee Schedule.

It is crucial that the definition of supervision be clarified. Most states have regulations that control the scope of practice for PAs. Under these regulations PAs are required to have a "supervising physician" who is responsible to oversee the care that they provide. This is different from Medicare's definition of a "supervising physician." Medicare does not require that one "supervising physician" is assigned to a PA, rather any physician who is in the office at the time that the PA provides services can be considered a "supervising physician." To

receive reimbursement from Medicare for services provided by a PA, you should submit claims to Medicare for the PA's incident-to services with the PIN number of the physician who was in the office at the time the service

was provided.

#### Who Will Be Reimbursed for Incident-To Services?

Under Medicare guidelines, clinical services provided by a practice employee may be billed as incident-to services. As usual, there are limits within this regulation. Medicare outlines the policy as follows:

When evaluation and management services are furnished incident-to a physicians service by a non-physician employee of the physician, not as part of a physician service, and the employee does not meet the criteria of Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist, the physician should bill code 99211 for the service.

What this translates to is that if your patient is seen by the office nurse, who is an LPN, and the physician is in the office but does not provide any services to the patient, services provided should be billed with a code 99211 (a minimal office visit). The chart should indicate that the physician was in the office when the

It is crucial that the definition of supervision be clarified.



services were provided and this justifies code 99211.

However, if a Nurse Practitioner provides services while the physician is in the office, the NP may bill for the level of E & M that best describes the service provided (99212-99215). Medicare policy regarding this scenario is explained as follows:

Covered services incident-to physician's service by non-physician practitioner, advises physicians that when evaluation and management are furnished incident to a physician's service by a nonphysician practitioner who meets the criteria in of Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist, the physician may bill the CPT code that best describes the evaluation and management service furnished.

#### **Unusual Circumstances**

An example of a situation that occurs frequently and has the potential to cause billing problems: A group practice will typically allocate patients to a particular physician within the practice. If one physician is out ill or on vacation, another physician from the practice will cover for them. It is essential when billing incident-to services in this situation that the covering physician's PIN is used rather than the PIN of the patient's regularly assigned physician. If you bill under the absent physician's PIN, this may look like fraudulent billing to an auditor.

Another example that can cause confusion for billers is when both a PA and the physician see a patient during the same office visit. Regardless of the reason for the patient being seen by both practitioners, only one office visit charge can be submitted.

For more information on any of the issues discussed in this article, or, if you have any guestions, please contact Kim Crawford, chief reimbursement liaison at MSMS at (517) 336-5722 or kcrawford@msms.org. The author is reimbursement liaison at MSMS.



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## To Lease or Not to Lease

Which Automobile Option Offers More Benefits?

By Stacy R. Lammers

ext to buying a home, acquiring an automobile may be one of the most important financial decisions you make. Issues like commitment, family dynamics, and lifestyle needs must be considered when shopping for a car.

Leasing rapidly has become an attractive alternative to purchasing, especially for people with busy, schedule-driven careers like physicians. It simplifies the process of getting an automobile, and offers many benefits over purchasing. The following guide offers helpful tips and basic information about auto leasing.

Leasing vs Buying

The biggest benefit of leasing is convenience. In simple terms, leasing offers all of the advantages of owning without the responsibility and hassle. When you lease, a trained leasing manager handles the details for you within your budget. For the term of the lease, all payments are organized, and repairs beyond wear-and-tear are covered. When you purchase, you are on your own to organize payments, repairs, general maintenance, etc.

"Besides convenience, one of the biggest reasons that doctors decide to lease is technology," said Wendy Ross, sales manager, Physicians Leasing Company, Inc. (PLC). "Since safety features and other extras change every few years, doctors want to be able to have the most advanced vehicle they can get for a low monthly payment."

Also, because most cars depreciate in value over time, it is not financially beneficial to try to build equity in them, which is what happens when a car is purchased. The capital paid in a purchase contract is lost over time as the car depreciates. When you lease, you simply pay the depreciation and finance charge, and walk away.

is that another entity is actually buying the car, not you." You pay the lessor (usually a bank, independent leasing company, or captive finance company like

ing the term of your lease.

GMAC) for the right to drive the vehicle dur-

Monthly payments are determined by adding the depreciation and finance charge together, dividing this sum by the lease term, and adding sales tax. At the end of the lease, there are five basic options: Turn in the vehicle, buy it for the residual amount, sell it to pay off the residual amount, re-lease it under a new agreement, or extend the existing agreement.

**Auto Leasing 101** 

Author Michael Scott Kranitz.

author of Look Before You Lease: Secrets to Smart Vehicle Leasing (Buy-Rite), explains that "the first

thing to know when leasing a car

Most leasing agreements include a limit on mileage, and if you exceed that limit, you are required to pay for the extra miles. The lessee also is required to pay for any damage incurred during the lease term above and beyond normal wear and tear.

Benefits also exist for those who lease: Possible tax deductions (especially for business users), no down payment, lower monthly payments, insurance protection, and long-term savings. Monthly lease payments are usually 35 to 45 percent lower than conventional financing.

Making the Choice

Use the following checklist of scenarios to help you decide if leasing is for you:

- You're in the market for a new car about every three years
- You usually put over 12,000 miles on your car each vear
- You dislike the hassle and haggling at tradein time
- You'd rather save or invest money than spend

"I found [PLC] to be extremely convenient to work with, and the service was excellent."

-Mark Washnock, MD



it on a down payment

- · You use your car for business and need accurate records for tax purposes
- You want a car, but not the responsibilities of ownership (arranging insurance, licensing, repairs, and ultimate disposal)
- You'd like to try a different car this year, but don't want to buy one that you might be unhappy with

If you have agreed with three or more of these statements, you may want to consider leasing. For more information, contact the Physician Service Group at (517) 336-7595 or mbloemers@msms.org or see the advertisement on the inside back cover of this issue.

The author is a communications specialist at MSMS.

"This is my first time leasing an automobile, and I have been very satisfied with the car, the terms, and the low payments."

-Mostafa Abuzeid, MD

#### Physicians Leasing Company Puts Physicians in the Driver's Seat

Ten years ago, Physicians Leasing Company, Inc. (PLC) began making automobile leasing easy for physicians. Today, PLC—an MSMS endorsed service since its inception provides leasing services for physicians in more than nine states, and has offices in Ohio and Florida.

"I found [PLC] to be extremely convenient to work with, and the service was excellent," said Mark A. Washnock, MD, an anesthesiologist from Marquette. "I got the car I wanted, and they delivered it to my home all the way from Ohio."

PLC negotiates leasing packages and agreements based on each individual physician's needs, and offers the following services to ensure convenience and flexibility:

- Tailor-made leases from 12 to 60 months (longer leases equal lower payments)
- · "Closed-end" or "walk away" leases
- Manufacturer rebates and incentives
- New car warranty presented with vehicle for repairs, maintenance

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According to PLC, it is important to note variables when comparing leasing companies. For example, some leasing companies may charge lower monthly payments than PLC, but those companies usually require substantial down payments, sometimes as much as \$5,000. If you divide this amount by the number of months in the lease term (e.g., 36) over \$130.00 per month could be added to your payment.

"This is my first time leasing an automobile, and I have been very satisfied with the car, the terms, and the low payments," said Mostafa I. Abuzeid, MD, an obstetrician-gynecologist from Flint. "I would go through PLC again because it's been a great experience."

For more information, contact PLC Sales Manager Wendy Ross at (800) 759-8880 ext. 226 or wross@autoleasingandsales.com. Visit PLC online: http://www.autoleasingandsales.com.

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### Health Care Insurance Premiums Project

Health care spending only increased by 4.7 percent in 1997, the lowest rate in 40 years, according to the Health Care Financing Administration (HCFA). In contrast, health insurance premiums are increasing as much as 14 percent in Michigan for 1999.

Why are premiums rising so fast if health inflation is relatively low? First, HCFA predicts that spending will double over the next 10 years. Because premiums are set in advance based on claims data, they reflect a three-year underwriting cycle. Insurers must anticipate these future cost increases, so the current premium is not likely to emulate the current underlying claim

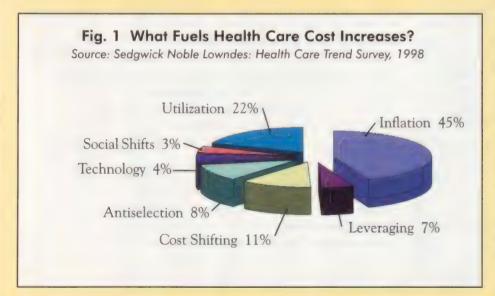
1996 the rate was only 0.5 percent. That period of intense insurer competition and its decreased profitability made the current premium increases somewhat inevitable.

According to analysts, 40 percent of the country's HMOs lost money in 1995. It was also estimated that only 35 percent were profitable in 1996 compared to 90 percent in 1993 and 1994. In order to regain profit-making status, they must resort to measures that include premium increases.

Such an increase in premiums alerts physicians to defend themselves against expected fee cuts, added delays in payment, and the

installation of more rules to an already complex payment system. In order to understand what influences health care premiums, we must examine the underlying inflation is the health system and how the insurance industry responds to it.

The rising cost of health care is due to many concurrent factors (Figure 1). Some of these factors present themselves more frequently and are more pronounced than others are. We are seeing these components reveal and repeat themselves in a type of cycle:



costs. Secondly, premiums were kept artificially low for the last few years as insurers competed for a larger market share. In 1992, when competition among plans was less fierce, premiums increased 10.9 percent in 1992. By

#### Technology

Some new technologies and medical advances save money—surgical procedures such as arthroscopy permit patients to leave the hospital the day of surgery—but some new procedures or equipment supplement rather than



replace their old counterparts as intended. For example, coronary angioplasty was expected to replace costlier, more complicated bypass surgery, but the numbers of both procedures are increasing. In 1984, fewer than 50,000 angioplasties and 200,000 bypasses were done, where, in 1989 approximately 250,000 angioplasties and 230,000 bypasses were performed.

Other developments are only "halfway technology"; they benefit, but do not cure. This means that follow-up care or even repeat procedures are often necessary, which add to overall health care.

#### Cost-Shifting

As a result of technological advances, cost containment efforts, and emphasis on preventive care came a transition from inpatient to outpatient care. Despite the fact that outpatient health care costs are significantly less than inpatient care, outpatient services generally tend to cost more according to most pricing schedules. This is because a higher percentage of cost-shifting occurs at the outpatient level. According to the Rand Corporation, it is common for the first day of hospital stay to cost twice as much as the last day after a long stay. In fact, they found that it was also common for hospitals to charge more for outpatient surgery than if the same procedure had been performed in the hospital. In keeping with a long-standing practice, it only makes sense that outpatient services induce health care costs to rise in order to maintain institutional cost shifting.

#### Utilization

The largest component of concern, in regard to health care costs and utilization, is the exponential expansion of the drug market. Prescription drug costs are increasing at two to three times the rate of medical care. Factors of concern include:

- Patents
- Reductions in manufacturer rebates or ties in rebates
- Aging population with higher rates of prescription drug utilization

- Beginning of life-enhancement drug frenzy
- ◆ Increased direct-to-consumer advertising
- Consolidation among wholesale drug manufacturers and drugstore chains
- ◆ Legal costs assumed with patent battles against brand-name drug producers

Not only are we seeing more drugs which are labeled "copy cat drugs," but recently we are moving the focus onto the manufacture and demand of life-enhancement or "life style" drugs and using drugs to replace other therapies or surgery. Most insurers that have raised premiums for 1999 cite pharmacy costs as the biggest influence in that decision.

#### Social Shifts

A predictable factor that poses a clear threat to the steady utilization trend is the aging of the population. The baby-boomer cohort, which makes up one-third of the U.S. population, will create a major challenge for the health care system. An elderly person uses approximately three times as much medical care as a younger person, and more than one million baby boomers will turn age 50 each year until the

#### Table 1 Medical cost increases, by plan type, 1998 and 1999

Source: Watson, Wyatt Worldwide, June 1, 1998

	1998	1999			
Indemnity	9%-11%	12%-15%			
Preferred provider organiztion	7%-8%	9%-11%			
Point-of service plan	5%-6%	7%-9%			
НМО	5%-7%	5%-7%			
Presription drug cards	12%-15%	15%-22%			

year 2011. By the year 2011, the over-65 cohort will account for 26 percent of the total U.S. population. Additionally, increases in life expectancy mean that in the year 2020, 7 million people will be 85 or older. This is a 274 percent increase since 1960.

Another element of rising health care costs is the various diseases and their growing com-



plexity. One of the most devastating health care costs is AIDS. Its onset in the early 1980s has added high, unexpected costs to our health care bill. In Michigan, a 1987 Greater Detroit Area Health Council survey of seven southeastern Michigan hospitals, which were treating approximately half of the state's AIDS patients, showed that the average inpatient hospital costs for each patient exceeded \$41,000. A study by the Centers for Disease Control in Atlanta placed lifetime inpatient and outpatient costs for each person with AIDS at \$60,000 to \$75,000 in 1984 dollars. The health care costs associated with the care and treatment of persons with AIDS are even more startling because the disease strikes many who are in their prime working years and would not otherwise be expected to require much intensive medical care.

#### Anti-selection

Anti-selection occurs when a health plan. and its financial future, is weighted heavily on the makeup of their enrollment. HMOs initially attracted younger, healthier employed people, who were likely to need less health care. The poor, elderly, and chronically ill remained in traditional insurance programs. This demographic profile has been important in reducing that financial risk for managed care plans and has increased the risk profile in traditional plans. As more Medicaid and Medicare beneficiaries are encouraged to switch to managed care plans. that dynamic will change.

#### Inflation

Medical inflation remains the largest component forcing health insurance premium increases. As of 1997, it represents almost half (45.3 percent) of the driving forces propelling costs. Unlike the rate of low inflation in the general economy, which is helping keep health care

costs in check, medical inflation is on the rise and working against it. In fact, medical costs are reaching double-digit increases in 1998 and will again in 1999 (Table 1).

According to the U.S. Bureau of Labor Statistics drugs, equipment and supplies tops the list for medical cost increases, accelerating from 1.5 percent in October 1997 to 2.3 percent in April 1998. Trends like these are what have forecasters worried about impending inflation. After a 25-year low of 2.5 percent for all health care inflation, health care inflation is expected to exceed 3 percent.

#### Conclusion

In 1997, the nation spent \$4,000 per person for health care, pushing total U.S. spending beyond the \$1.0 trillion for the first time ever. Approximately 57.5 percent of that \$1.0 trillion was physician directed or controlled, and 22.3 percent went directly to physician services. Because physicians are connected to such a large portion of the health care dollar, employers and plans will increase the pressure on physicians to slow the growth in spending. Physicians must prepare to examine these components of health care costs and work collaboratively with others to design strategies to target resources in the most efficient and effective way possible.

#### For Further Information

For further information, please contact Laura Campbell, MSMS Assistant for Health Care Research at (517) 336-5711 or lcampbell@msms.org. Or check out our Website at http://www.msms.org.

#### MEDICAL SOCIETY MICHIGAN STATE

MSMS Women Physician Leaders and Women Lawmakers celebrate women involved in the political process. Women legislators and women physicians have many common interests and this reception gives us an opportunity to share our concerns and continue to build our relationships.

Michigan State Medical Society Fourth Annual Women Physicians and Women Lawmakers Reception Wednesday, March 10, 1999 5:30 to 8:00 p.m. MSMS Headquarters in East Lansing

Join your colleagues at this special event.

To attend, please contact Gregory T. Aronin, Director, Government Relations at 517/ 336-5739 or Sherry L. Barnhart, Staff, Committee on Concerns of Women Physicians at 517/336-5786.

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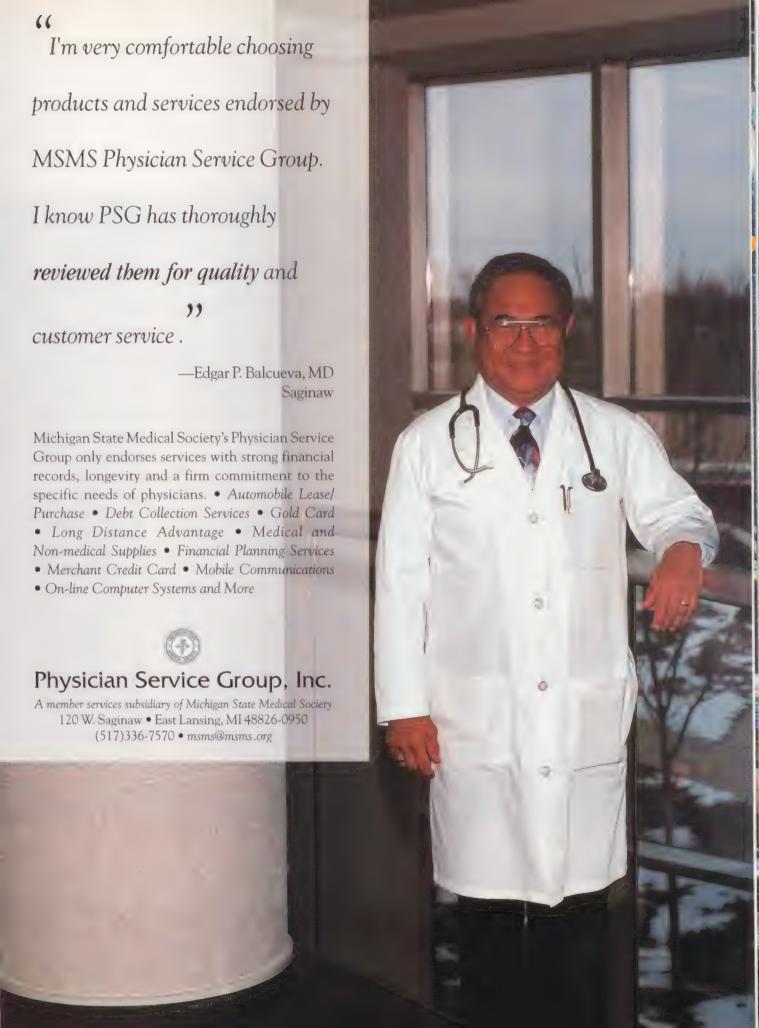
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# Toward Physician-Assisted Living

**Improving** End-of-Life Care

By Gregory Brusstar

 $oldsymbol{T}$  hrough the debate and defeat of Proposal B last fall, Michigan's citizens sent this message: While assisted suicide is not the answer, we want and need the medical community to improve the care we receive at the end of life. MSMS' Task Force on End-of-Life Care has responded with an ambitious agenda, and Michigan physicians are taking the leadership role in meeting medicine's duty and our patients' mandate.

fter a diverse coalition, which included many health care groups, successfully opposed Michigan's recent assisted-suicide ballot proposal (Proposal B), physicians recognized that now is the time to take a leadership role on the issue.

Task Force to Face Issues

With so little available data, so many questions to ask, and so much controversy surrounding the issue, MSMS created a 20-member task force to frame the questions and to confront the wide collection of end-of-life care issues.

"The ballot initiative was a wake-up call for physicians to get their act together and be leaders in the area of end-of-life care," says MSMS President Cathy O. Blight, MD, who is chair of the newly-appointed MSMS committee, dubbed the Task Force on End-Of-Life Care. "Most importantly, we want to let patients know there are other options available for end-of-life care besides assisted suicide. The issue of assisted suicide gets overplayed in Michigan because of Jack Kevorkian. Hospice care doesn't get nearly the media attention it should."

The task force's role will be to address endof-life issues thoroughly and with open minds, Doctor Blight says. Assisted suicide is a significant issue, physicians say, but many suggest it is a secondary one that affects surprisingly few patients. A broader focus on improved access to and delivery of quality end-of-life care is perhaps more important, physicians say. Hospice advocates say assisted-suicide ballot initiatives are not the answer to end-of-life care. But they admit the initiatives have served a useful purpose: to bring end-of-life care issues out in the open and to promote wider awareness and use of hospice care.

Call for Better Palliative Care

"Proposal B and Kevorkian's activities are indictments of medicine," said John Finn, MD, medical director of the Hospice of Michigan, and a member of the MSMS Hospice Medical Directors committee. "Somewhere along the way, modern medicine with its science-based technical approach has removed itself from the people. These initiatives are a clarion call for medicine to rediscover palliation."

Two existing MSMS committees—the Bioethics Committee and the Hospice Medical Directors Committee—have been dealing with end-of-life care issues for many years. For example, the Bioethics Committee has been working to implement the goals of Last Acts, a national coalition that has the long-term goals of:

- ◆ Improving communication and decision making with respect to end-of-life care
- Encouraging health care institutions to change their approach to the care of dying
- ◆ Changing American attitudes toward death.

Last year, with the instigation of the Bioethics Committee, MSMS organized two painmanagement conferences and will hold another in the spring of 1999. In addition, the group helped craft and promote legislation, called the Uniform Health Care Decisions Act, which expands the usefulness of advance directives. The Hospice Medical Directors committee has been educating physicians about various aspects of hospice care, including promoting earlier use of hospice. Many members of these committees are serving on the Task Force, which met for the first time in late January.

Some topics likely to be at the top of the Task Force's agenda include educating physicians about hospice and palliative medicine, promoting increased referral of hospice care among physicians, urging medical schools and residency programs to include hospice care in their curricula, and educating patients about existing end-of-life care options.

"We will be open to ideas and suggestions," says Doctor Blight. "This is a brand new project. We've looked at the pieces of the issue before,

"The ballot initiative was a wake-up call for physicians to get their act together and be leaders in the area of end-of-life care."

-MSMS President Cathy O. Blight, MD but not the problem as a whole. We'll identify the things we think we can do best. At the same time, other groups representing hospitals, hospices, nursing homes, nurses, and the legislature are working on end-of-life issues. Perhaps we can eventually organize an end-of-life care summit and be a convener of these groups to make sure we're all doing the most without significant duplication of effort."

### **Educating Physicians** about Hospice Care

Consider these statistics: the average length of care for a hospice patient in Michigan was 20 days in 1997. In addition, between 30 and 40 percent of patients die within seven days of initiating treatment. Given the six-month

Medicare hospice benefit, it's clear that physicians are under-utilizing this care option in Michigan, hospice advocates say.

"If we were well educated on end-of-life care, we'd be referring them earlier," said Paul DeWeese, MD, member of the Task Force and a newly elected state representative from Williamston. "A large part of the medical community insists on doing painful, fruitless procedures that rob people of their quality of life. We're robbing people of precious moments with children and grandchildren. We need to be up front and say 'there is no treatment available that has shown promise.' Physicians need to be able to say 'I'll be with you as your physician. Together we'll help you live a full, natural life to the end.' This is helping a person have a 'good death.' "

#### Last Acts: A National Coalition for Improving End-of-Life Care

Michigan State Medical Society is a member of Last Acts, a national coalition of 75 organizations and hundreds of individuals whose goal is to raise the nation's awareness of the need to improve care for the dying and to promote the sharing of issues and solutions at the national, state, and local levels.

- Last Acts seeks to engage professionals and the public in these three areas:
- Improving communications and decision-making with respect to end-of-life care
- Changing health care and health care institutions with respect to how they approach the care of dying people
- Changing American culture and attitudes toward death

Visit the Last Acts Website at http://www.Lastacts.ora

#### Dispelling Misconceptions of Hospice Care

Improving physician education in hospice care is definitely needed, says Doctor Finn of the Hospice of Michigan. "I don't believe physicians understand how skilled the hospice team is," says Doctor Finn. "They don't sit in on hospice team meetings. They [physicians] have a superficial understanding of what hospice is. Some think it's euthanasia, some think it's TLC. They don't view it as a mainstream medical service. That's why hospice care is so vastly under-utilized. It's estimated that only 25 percent of the terminally ill use hospice care. Shouldn't that be 50 percent? Or 75 percent?"

Physicians acknowledge

the need for more training in hospice and palliative medicine. Studies repeatedly have shown that physicians generally under-recognize and under-treat pain and depression in dying patients. But that's all beginning to change.

#### A Time for Change

"In the past several years, we're noticing that physicians have a better understanding of hospice care," says Tom George, MD, medical director of Hospice of Greater Kalamazoo, cochair of the MSMS Hospice Medical Directors committee, and a member of the Task Force. "The level of knowledge about pain control has improved among admitting physicians."

Taking advantage of the hospice medical director's knowledge can lower the educational barrier. Even if an admitting physician lacks

"Physicians need to be able to say 'I'll be with you as your physician.
Together we'll help you live a full, natural life to the end.' This is helping a person have a 'good death.' "

—Paul DeWeese, MD

"In the past several years, we're noticing that physicians have a better understanding of hospice care."

-Tom George, MD

training in hospice care, Doctor George says, he can work with the medical director, who can provide a pain management plan for the physician's approval.

In order to promote a better understanding of end-of-life issues, MSMS has developed an array of conferences and seminars geared toward physician education. In conjunction with the Michigan Osteopathic Association, Michigan Nurses Association, and the Michigan Health and Hospital Association, a three-part educational video conference has been developed on pain management on February 24, March 30, and September 22. In addition, the 3rd Annual Conference on End-of-Life Care titled "Controversies in End-of-Life Care," will be held on May 18, 1999 at the Grand Plaza Hotel in Grand Rapids.

A recent American Medical Association initiative aims to improve physician education on end-of-life issues. The program, called Education for Physicians on End-of-Life Care (EPEC), is a national train-the-trainer program funded in part by the Robert Wood Johnson Foundation, which has provided millions of dollars toward educating health professionals about end-of-life issues. The program curriculum will address advance care planning, communication of a life-threatening diagnosis, management of imminent dying and bereavement, and responding to requests for assisted suicide. More than a dozen physicians from Michigan are scheduled to attend the training. The next training conference will be held February 19-21 in Atlanta.

Another important avenue for improving physician education is though the American Association of Hospice and Palliative Medicine (AAHPM). Created in 1988, the AAHPM is the only organization for physicians dedicated to the advancement of hospice and palliative medicine. It organizes CME conferences and educational opportunities for physicians.

#### Significant Events Affecting **End-of-Life Care**

End-of-life care, including the issue of assisted suicide, has risen to a position of national prominence through events of the last 25 years. In 1975, the Karen Ann Quinlan case opened the public policy debate regarding end-of-life medical care decisions and death with dignity. Quinlan suffered a respiratory arrest that left her in a permanent vegetative state. Her family undertook a lengthy legal battle to remove her from life support, and eventually the family was granted that right. Twelve years later in 1986, the AMA adopted a position that, with informed consent, physicians could withhold or withdraw treatment from patients who are close to death. The AMA also concluded that physicians who have obtained informed consent could discontinue life support if a patient is in a permanent vegetative state. In 1990, the U.S. Supreme Court ruled in Cruzan vs Director, Missouri Department of Health that patients have a constitutionally protected right to refuse unwanted medical care.

In the early 1990s, the assisted suicide debate began on the West Coast. California and Washington voters narrowly defeated assistedsuicide initiatives. During this time, Jack Kevorkian had assisted in several suicides in Michigan, forcing the issue of assisted suicide from a different angle into national headlines and into the courtroom. In 1994, Oregon became the first and only state to legalize assisted suicide. The constitutionality of the measure was

"I'm encouraged that an increasing number of doctors are certified in hospice and palliative medicine," says Doctor Finn, who serves on the AAHPM board of directors. "What we're working toward is subspecialty recognition. One might argue that care of the dying is a primary responsibility for all physicians, when in reality it's a small number of physicians who are comfortable at the bedside of a patient who is dving."

In addition, the related American Board of Hospice and Palliative Medicine (ABHPM) grants board certification in hospice and palliative medicine. Currently, about 1,400 physicians nationwide have achieved certification. according to Doctor Finn. The certification exam covers the following topics:

- · Hospice and palliative approach to care, including standards of care and the hospice Medicare benefit
  - Death and dying issues such as psychoso-

cial issues, physiological changes, spiritual issues, and grief and bereavement

- Pain treatment in cancer and non-cancer patients
  - Management of non-pain symptoms
  - Communication and teamwork
  - Ethical and legal decision making

#### Other Barriers to Increased Use of **Hospice Care**

Other barriers to use of hospice care include Michigan's prescription laws, Medicare reimbursement rules, and American cultural attitudes.

Michigan's current prescription regulations require that physicians apply for special forms to be used specifically when prescribing Schedule II drugs (which include the opiates used in hospice care). Since prescribing of opiates is monitored by the state to prevent diversion for illegal sale, many physicians are hesitant to

immediately challenged and was upheld in 1997. As the issue was debated nationally, the AMA came out opposing physician-assisted suicide, saying it is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication." Many state medical societies, including MSMS, adopted this position at the state level soon thereafter.

Then in 1997, two important decisions came out of the U.S. Supreme Court. The cases affirmed the right of competent patients to refuse unwanted medical care and to receive adequate pain treatment at the end of life—even if it might hasten death. In both cases-Washington vs Glucksberg and Vacco vs Quill—the court found there was no constitutional right to assisted suicide and turned the matter back to states to decide whether to ban or legalize assisted suicide. Since that time assisted-suicide initiatives in several states, including Michigan, have been presented and all have been voted down. Oregon continues to stand alone in its legalization of assisted suicide.

"The struggle between cure and care is always difficult. But people have to get over the concept that going on a hospice program means they're giving up."

-Fred Isaacs, MD

prescribe these drugs, especially in the high doses required for pain management for hospice patients for fear of being investigated.

Many physicians believe this regulatory program needs to be eliminated to reduce the barriers to increased hospice care. "The fact is physicians feel inhibited in prescribing appropriately," said Howard Brody, MD, PhD, co-chair of the MSMS Bioethics Committee. "There is no good evidence that this law has kept illegal drugs out of the market. It should be eliminated."

As evidence of the law's "chilling effect," he said many physicians never even bother to order the forms required to prescribe Schedule II drugs.

Another barrier to hospice care is the Medicare benefit, which provides for six months of hospice care. Medicare requires the patient to choose between palliative care and curative care, but they may not choose both. This poses a quandary for patients that physicians believe is unfair and

limits use of potentially effective hospice care in many cases.

Cultural attitudes also are a barrier for hospice care. In America, death is a topic that rarely is discussed between physicians and patients or among family members. It's a topic that is repressed, delayed, or altogether neglected. This makes the problem of discussing the option of hospice care very difficult.

"There is a mental barrier of the doctor, the patient, and the family in accepting that the

#### **Hospice Projects** Recently Received \$9.1 Million in Grants to Pioneer Innovations in **End-of-Life Care**

Last fall, 21 health care institutions, including two in Michigan, received grants totaling \$9.1 million for researching better ways of delivering end-of-life care.

The Henry Ford Health System received \$440,000 for an innovative multilayered program designed to ease barriers to communications that patients may face as they make end-oflife decisions.

The University Michigan's Comprehensive Cancer Center received \$450,000 for a program to study the effect of introducing hospice care to terminally ill patients earlier on in their illnesses.

Hospice of Michigan will collaborate not only on the University of Michigan grant, but also on the University of Chicago's project to experiment with introducing hospice care earlier in the progression of Alzheimer's disease.

patient is nearing the end of life," said Fred Isaacs, MD, medical director of the Hospice of Lansing, co-chair of the MSMS Hospice Medical Directors committee and a member of the Task Force. "The struggle between cure and care is always difficult. But people have to get over the concept that going on a hospice program means they're giving up."

In short, telling a patient there is no cure for their ailment is extremely difficult for physicians and even unthinkable for some. "It's difficult to say to a patient, 'I can't cure your heart failure, you'll always be short of breath, but I'll be here to help you feel better," " says Doctor Isaacs. "It's like men saying they're lost. It doesn't come across our lips very easily."

The change to a more open attitude toward end-of-life issues is necessarily long term because it involves changing the deeply held attitudes about death. "We were taught in medical school that death was

a defect, that it was the enemy," says Doctor DeWeese. "This is one reason why physicians are afraid to address death earlier. The average referral to a hospice in this country is in the last weeks of life. That's why it's so important to address these issues in medical school."

#### **Urging Medical Schools to Teach Hospice Care**

Hospice and palliative medicine often is a neglected topic in medical schools and residency programs. One study reveals that less than 10 percent of internal medicine training programs include supervision and treatment of dying patients who are receiving palliative care.

"We believe it's extremely important that medical schools develop formalized programs for teaching pain management," says Doctor Blight. "Students should be exposed to end-of-life care issues early in their training."

No one could agree more than Doctor Brody, who is professor of Family Practice at the Michigan State University Medical School and serves as director of MSU's Center for Ethics and Humanities in the Life Sciences.

"What would be ideal is that we won't have this conversation 20 years from now," says Doctor Brody. "All the future doctors would understand hospice and palliative care because they would have had it in medical school.

Schools should be insisting that students know about hospice care before they graduate, just as they need to know about the intensive care unit."

Doctor Finn believes this issue should be addressed to medical school deans. "When you survey medical schools and review the training experience of interns and residencies and fellowships, there is little opportunity to gain competencies in this area," reports Doctor Finn. "It needs the attention of medical school deans. It must come from the top down or it won't be seen as important."

#### An Organization for **Physicians: American Academy of Hospice** and Palliative Medicine

Originally organized as the Academy of Hospice Physicians in 1988, the American Academy of Hospice and Palliative Medicine (AAHPM) is the only organization in the United States for physicians dedicated to the advancement of hospice and palliative medicine, its practice, research, and educa-

The organization's objectives include:

- ◆ To provide hospice physicians with peer support and opportunities for an interchange of information and experiences
- To foster the development of research on hospice care
- ◆ To develop a credentialling mechanism for hospice physicians
- ◆ To foster accreditation of physician training programs

Visit the AAHPM Website at http://www.aahpm.org

#### **Informing Patients of** the Hospice Option

Assisted suicide initiatives have been driven by the public's increasing desire for more control and less pain at the end of life. Until that need is met, many project initiatives such as these will continue to surface.

Although public opinion is divided on the issue of physician-assisted suicide, studies and polls consistently show that a majority of Americans, including physicians, favor a more open and accessible physician-assisted suicide. Accordingly, opinion polls in Michigan taken before the Proposal B vote revealed a majority in favor of physician-assisted suicide, says Doctor Brody.

"The majority of people want physician-assisted suicide to be available," says Doctor Brody. "For those in favor of it, the reason most often cited is control. People are fearful that the current

medical system doesn't give them adequate control over dying." Even though this particular proposal was voted down, there is no evidence of a shift in public opinion away from supporting the concept, he added.

One group of researchers contend that a high public approval rating, though compelling, may be confounded by the public's general lack of knowledge and understanding of palliative care or their right to refuse unwanted treatment. Hospice advocates are convinced the public's desire for a more dignified death can be met, for the most part, with a combination of better

information and improved access to and delivery of and hospice and palliative care.

"If medicine is doing its job, Proposal B and Jack Kevorkian become unnecessary," says Doctor Finn.

#### **Educating the Public**

Public education about hospice care is already a high priority for the Michigan Department of Community Health (MDCH), which is funding several health provider and public education programs. Michigan's health department is the only one in the nation to dedicate funds to

hospice and pain management programs, according to Jim Haveman, MDCH director.

"Our position has always been that physicianassisted suicide or any self-selection process makes bad public policy," says Haveman. "There are other laws, such as the Durable Power of Attorney, and others choices that patients have that they don't know anything about. So we're providing money for the educational process."

In fact, the Department has set aside \$750,000 for educating health professionals and the public about hospice care and end-of-life options. Educational activities include sponsoring hospice and pain management seminars for physicians and nurses, running print and radio advertisements to improve public knowledge of

#### Certification in Hospice and Palliative Medicine The American Board of **Hospice and Palliative** Medicine

The American Board of Hospice and Palliative Medicine grants certification to physicians in Hospice and Palliative Medicine. The examination includes these topics: hospice and palliative approach to care, death and dying issues, pain in cancer and non-cancer patients, management of non-pain symptoms, communication and teamwork, and ethical and legal decision-making.

Visit their Website at http://www.abhpm.org

the issues, and funding a position at the Michigan Hospice Organization to answer public inquiries about hospice

In addition to public education, the Department will continue meetings of its multidisciplinary committee called Circle of Life, created to raise public awareness of end-of-life issues during its campaign against Proposal B.

Another consortium organized by the Michigan Hospice Organization (MHO), called the Partnership for Appropriate and Compassionate Care, is working to improve

provider and public education of end-of-life

"We're concerned that people have options in end-of-life care," says Suzanne Homant, executive director of MHO. "People choose suicide when they think they don't have any options."

Many hospice advocates say those options are already available to patients. Granted, there are problems to solve. And changing cultural attitudes toward death is certainly a long-term proposition. But many physicians, health care providers, and public leaders hope with improved access and education, hospice and palliative care will become more widely known as the standard of care.

The author is an Okemos-based freelance writer.

#### 1999 MSMS Pain Management Seminars

A coalition that includes MSMS, Michigan Osteopathic Association (MOA), Michigan Nurses Association (MNA), and the Michigan Health & Hospital Association is pleased to present "Clinical Trends in Pain Management"—a series of three videoconferences intended to increase knowledge and skills in end-of-life care.

Following are dates and times for the videoconferences:

#### Pain Management in the Context of **End-of-Life Care**

February 24, 1999, 4:00-6:00 p.m.

#### **Cancer Pain Management** March 30, 1999, 4:00-6:00 p.m.

**Chronic Pain Management** 

September 22, 1999, 4:00-6:00 p.m.

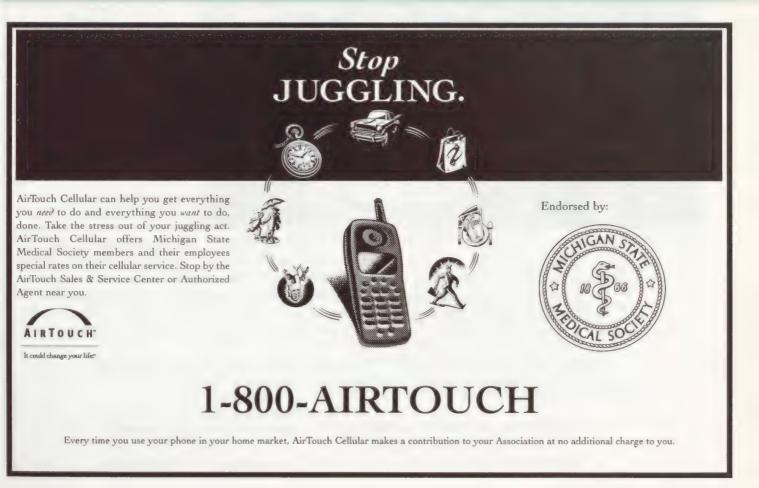
These programs can be seen at the following sites:

- ◆ Borgess Medical Center, Kalamazoo
- ◆ Carson City Hospital, Carson City
- ◆ Henry Ford Health System, Detroit
- ◆ Ingham Regional Medical Center, Lansing

- ◆ Lakeland Regional Health System, St. Joseph
- ◆ Marguette General Hospital, Marguette
- ◆ McLaren Regional Medical Center, Flint
- ◆ Munson Medical Center, Traverse City
- ◆ Spectrum Health, Grand Rapids
- ◆ St. Joseph Health System, Tawas

A third day-long conference titled "Controversies in End-of-Life Care," will be presented by MSMS, in conjunction with the Michigan Department of Community Health, MNA, MOA, Hospice of Michigan, and the Michigan Hospice Organization on May 18, 1999, at the Amway Grand Plaza Hotel in Grand Rapids. The 1999 MSMS Mackinac Island Bioethics Conference—"Integrity in the Face of Change"-will be held on October 15-17.

For more information or for questions about CME credits, please contact Tom Seely at at (517) 336-5770 tseely@msms.org.



# **Door-to-Door Service**

Service Reps Provide Assistance with Benefits and Services

#### By Rebecca Blake

ember Service Representatives (MSRs) were established at MSMS for a simple purpose—MSMS exists to help its members. MSMS wants to be sure its members know this, and to then provide them the help that they need.

With doctors and their staffs being busier than ever before, it made sense to instill a system to assist physicians in a more convenient environment—in their offices.

After two years, the program is a proven success. Not only do the MSRs carry information effectively. The MSRs were created to respond to the needs of Michigan physicians. Your MSR is committed to ensuring that physicians and their office staff optimally utilize the benefits and services offered to its members.

The MSRs travel throughout the state to meet individually with physicians and their staff to provide information on new and existing services available to members. Scheduling an appointment with your MSR is an opportunity to discuss ways that MSMS can serve you more

> efficiently. It is our goal that your practice is able to maximize the potential of the extensive resources of MSMS and your county medical society.

#### Does MSMS offer assistance to practices with billing and contracting issues?

MSMS has numerous resources to guide physicians in the changing health care environment. Kimberly Crawford, chief. Reimbursement Liaison is available to assist practices with reimbursement issues.

Ms. Crawford may be contacted at (517) 336-5722 or via email at kcrawford@msms.org.

Contractual relationships have been a cause of concern for many physicians. As a means of response, MSMS has created a Managed Care Contracting Checklist to alleviate questions and provide a resource tool for physicians. This checklist is designed to address definitions, physician obligations, billing requirements, compensation, utilization review, quality assurance, termination, dispute resolution process, amendments, and miscellaneous provisions.



MSMS Member Service Representatives (left to right) Rebecca Blake, Angela Criswell, and Colin Ford.

to doctors, but they bring back to MSMS physician questions and concerns as well, funneling them to appropriate staff members to get answers back quickly to the doctors. This column will appear six times per year, and will highlight questions from MSMS physicians, answers, and pertinent information to enhance your practice.

#### What is the purpose of the MSR?

The Michigan State Medical Society (MSMS) is dedicated to serving its members The checklist was created by Charles R. Cuzydlo, ID, chief, Legal and Regulatory Affairs. He is available to address any questions or concerns regarding the checklist at (517) 336-5714 or via email at ccuzvdlo@msms.org. To order copies of the Managed Care Contracting Checklist, please contact Patricia Bokovoy at (517) 336-5723 or via email at pbokovov@msms.org.

#### Does MSMS provide access to disability insurance?

Disability insurance may be purchased through Stratton, Cheeseman, and Walsh (SCW). SCW is the exclusive insurance agency

servicing Mutual Insurance Corporation of America (MICOA), formerly Michigan Physicians Mutual Liability Company (MPMLC). SCW provides all professional and personal lines of insurance including professional liability, workers compensation, business owners policy, home-owners, auto, and life. Physicians, employees, staff, family, and friends are eligible to take advantage of their competitive rates. SCW is endorsed by MSMS.

To schedule an appointment with your MSR or inquire about MSMS services, please contact the Member Service Representative Department at (517) 336-5749.

The author is a Member Service Representative.



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# A History Lesson

Civil War Buff Shares His Passion

By Nancy Hale Brown

nce let the black man get upon his person the brass letters, U.S., let him get an eagle on his button, and a musket on his shoulder and bullets in his pockets, and there is no power on earth which can deny that he has earned the right to citizenship in the United States."

- Frederick Douglass

Those words moved many African Americans to enlist in the Union Army and fight for their freedom during the Civil War.

When Lawrence Reynolds, MD, discovered that one of his ancestors was among the soldiers, he enlisted himself in a Civil War group.

"Although it is recorded in history," says Doctor Reynolds, who runs a federally funded clinic in Flint, "many people don't know that 10 percent of the troops were black. I don't say African American because they were not citizens at the time."

Since 1984 Doctor Reynolds has "fought" with the 102<sup>nd</sup> U.S. Colored Troop, based in Flint and Detroit. The troop has 15 members in uniform and five women in period dress.

"Ours is a living history group," says Doctor Reynolds, whose wife is also involved in the group. "We use battles and camps as props. But we talk about history and march in parades. Our main goal is education."

The troop includes mainly retired persons from many occupations: a Coast Guard commander, Ford workers, and businessmen.

Dressed in period clothing, the group does about 15 demonstrations a year in Michigan, Ontario, and Williamsburg, VA. They march in parades, and share history at schools, Greenfield Village, Henry Ford Museum, libraries, and prisons. Annually on Veteran's Day they visit Elmwood Cemetery in Detroit, where two Civil War veterans from the 102<sup>nd</sup> are buried.

"When we do a demonstration, it is like we are actually moving troops," Doctor Reynolds

says. "We have to bring weapons, food, water, toilet supplies. We have to pack and unload. It seems we assume a military structure because there is so much work behind what we do."

The men wear heavyweight, wool, blue Union uniforms provided by Fall Creek Sutlery in Whitestown, Indiana. The

women wear long, authentic cotton dresses and bonnets. Six, two-man tents are set up according to Union specifications. There are also tents for a captain and sutler, the civilian who provided the troop necessary provisions, including clothing. The sutler tent is used to display pictures of life during the Civil War, battle maps, books, and a living history group recruitment brochure.

After the lengthy set up, troop members have fun taking on new, historically authentic personalities.

"I become Doctor Martin Delaney," Doctor Reynolds says. "I was the son of a free black woman and enslaved man. I fought for my education before the Civil War. I recruited soldiers during the war and then became a surgeon in the Union Army. By the end of the war, I was a field officer."

Other members read historic letters. One is addressed to President Lincoln: "I'm not sure my family is getting my pay . . . " Another is from a woman desperate to find her soldier husband.

"We try to get people to understand the courage they had and the sacrifices they made for what they believed in," Doctor Reynolds says. "Of course, there were some people who just took the job for the pay (he laughs)."

Doctor Reynolds unfortunately knows very little about the sacrifices his distant relative made during the war.

"All I know is what my grandmother told me," he says. "He was a runaway slave who had

"We try to get people to understand the courage they had and the sacrifices they made for what they believed in."

—Lawrence Reynolds, MD



102nd U.S. Colored Troop aboard the H.M.S. Rose with War of Independence Re-Enactors in background. Left to right: Bruce Clark; Lawrence Reynolds, MD; Ross Fowler, Commander, USCG-Retired; William Singleton (deceased).

to disappear after the war because he wasn't welcome in Georgia."

But Doctor Reynolds quickly points out that the president of the 102<sup>nd</sup> living history group is the great-great grandson of Alfred White. White fought with the "real" 102<sup>nd</sup>.

White was among approximately 180,000 African-Americans comprising 163 units that served in the Union Army. Both free African-Americans and runaway slaves joined the fight.

The 102<sup>nd</sup> troop was formed in response to the Union Army's desperate need for manpower. The troop was organized in 1863, trained in Detroit, and mustered into service in 1864. The total enrollment of the troop was about 1,673 men. Of that, 128 lost their lives and 114 were discharged with disabling wounds suffered fighting Confederate troops.

"By being in the Civil War, we became citizens of the United States," Doctor Reynolds says. "From citizenship, you can go to civil rights. They were remarkable men and women."

The men and women in the living history group are remarkable, too, Doctor Reynolds adds. Even though he was in pain and could barely walk, William Singleton, a living history group member, participated in the troop's Veteran's Day event last September. He died in January at the age of 70 and was buried in his Civil War uniform.

"He wanted to give his leathers (pouch, cartridge, belts, buckles) to his son," Doctor Reynolds says. "So we ordered new ones for him to be buried in. Out of great respect, the sutler company refused to charge us."

The author is an Okemos-based freelance writer.

**During February**, the 102<sup>nd</sup> troop will have ongoing demonstrations at Henry Ford Museum, in honor of Black History Month. Persons wanting more information about the troop can call Ross Fowler, president, at (313) 869-4669.

## Fraud and Abuse

Understanding Definitions and Establishing Compliance

By Charles Cuzydlo, JD

he federal government recently has made health care fraud a top priority. In fact, Janet Reno, Attorney General of the United States, stated: "Let me make the message very, very clear. We have made health care fraud a priority and we will pursue it as vigorously as we can." The risks associated with health care fraud and abuse are great, they include: criminal prosecution coupled with significant fines and incarceration; civil penalties with fines reaching as high as \$25,000 per claim and treble damages; asset freezing and qui tam lawsuits.

The primary laws employed by the federal government include the civil False Claims Act (31 U.S.C. §3729 et seq.), the Civil Monetary Penalties Act (42 U.S.C. §1320a-7a), the Federal Anti-Kickback Statute (42 U.S.C. §1320a-7b), and the Stark Amendment (42 U.S.C. §1395nn).

First, the civil False Claims Act (31 U.S.C. §3729 et seg.), which was enacted to deter defense contractors from over charging the government during the Civil War, has been applied in the health care field. This law prohibits a person from knowingly presenting or causing to be presented to the federal government a claim for payment or approval. Civil fines ranging from \$5,000 to \$10,000 per false claim can be imposed. In addition, the government can recover treble damages. Finally, the government is not required to prove specific intent-it must only prove that the provider acted in deliberate ignorance of the truth, reckless disregard of the truth, or their conduct has established a pattern of "in-artful coding."

Another statute (18 U.S.C. §287) imposes criminal sanctions for submitting false claims to the government. Potential sanctions include prison terms of up to five years (10 years for conspiracy) and fines that may exceed \$250,000.

Secondly, the government may employ the Civil Monetary Penalties Act (42 U.S.C. §1320a-7a). This law is similar to the civil False Claims Act, but it specifically targets health care fraud, such as knowingly presenting or causing to be presented a claim for an item or service that was not provided as claimed. Civil fines can range up to \$10,000 per claim, and treble damages can be assessed. Also, a provider can be excluded from participation in Medicare and Medicaid. Once

again, proof of specific intent is not necessary.

Third, the Federal Anti-Kickback Statute (42 U.S.C. §1320a-7b), which was enacted in 1972 to curtail defense contractor kickbacks, was extended to Medicare and Medicaid in 1977, and then to all federal health programs (except Federal Employees Health Benefit Plan [FEHBP]) in 1996. It prohibits exchanging anything of value for referrals, or for the purchase/lease of goods or services – including professional discounts. The criminal penalties include a fine of \$25,000, up to five years imprisonment, and mandatory exclusion from the Medicare and Medicaid programs.

Finally, the Stark Amendment (42 U.S.C. §1395nn) prohibits referrals by physicians to certain entities with which the physician, or a family member, has a financial relationship. A financial relationship includes investments, compensation arrangements, discounts, and direct and indirect relationships as well. Stark regulates not only the Medicare program, but also the Medicaid program, the FEHBP and the health benefits program for federal prisoners. Stark prohibits referrals for 11 types of services: Clinical laboratory services; physician therapy services; occupational therapy services; radiol-



ogy services, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and internal nutrients, equipment and supplies; home health services; out-patient prescription drugs; and in-patient and out-patient hospital services. A provider that violates Stark faces civil penalties of \$15,000 per improperly submitted claim and/ or \$100,000 for entering into circumvention schemes. In addition, amounts collected in violation of Stark must be refunded promptly.

Other theories of prosecution at the prosecutor's fingertips include mail fraud, wire fraud, conspiracy, false statements to a government agent, obstruction of justice, money laundering, criminal forfeiture, immediate freezing of assets, and investigative demands.

Two Michigan cases of great importance to physicians are Indenbaum, M.D. vs Michigan Board of Medicine; 213 Mich. App. 263 (1995) and Peoble of the State of Michigan vs Motor City Hospital and Surgical Supply, Inc. et.al.; 227 Mich. App. 209 (1997). In Indenbaum, the court held that the physicians violated a statute that prohibits physicians from directing or requiring a patient to have a procedure performed at a business in which the physician has a financial in-

terest. The physicians referred patients and specimens to a facility in which they were limited partners, but had posted a notice disclosing their relationship and confirming that patients could use alternate facilities and that the physicians derived income strictly in proportion to extent of their partnership interests unrelated to the revenue generated from referrals. The court in Motor City Hospital and Surgical Supbly, Inc. et.al., held that the government, in prosecuting a person under the Michigan Medicaid False Claims Act and the Health Care False Claims Act, need only prove general intent as opposed to corrupt intent. Under the theory of general intent, the government must prove, beyond a reasonable doubt, that the provider purposefully or voluntarily performed the wrongful act (e.g., receipt of a rebate or referral fee). The government is not required to prove that the provider knew his or her acts were wrongful.

Prior to charging a provider with a fraud and abuse violation, an investigation may be conducted by the FBI, HHS Office of Inspector General (HHS/OIG), Defense Criminal Investigation Service (DCIS), Postal Inspectors, State Attorney General/Medicaid Fraud Control Unit (MFCU), U.S. Attorney General's Office, or HCFA.

The investigative methods employed by these agencies include both covert and overt operations. The covert stage includes the review of findings from a random audit, comparison to peer usage, contact with patients, and undercover operation. Overt investigative strategies include: investigative demand, surprise agency inspection, search warrant—which may be served along with a Grand Jury subpoena for other records or Grand Jury subpoenas to employees, and asset seizure/freezing.

Areas that receive the greatest investigative attention are physician self referrals, upcoding, lab bundling, physicians at teaching hospitals, provision of medically unnecessary services, The government is not required to prove that the provider knew his or her acts were wrongful.

substandard quality of care, charging above cost for drugs, denial of care, denial of payment, and partial hospitalization. While invalid defenses include relying on consultant advice, if the claim is not explicitly false, employee error, rogue employee or agent, or being unaware of an employee's prior history of fraud.

To help avoid being placed "under the scope" of a governmental investigation the provider should take steps to avoid, at a minimum, the routine waiver of co-pays, deductibles, default coding, changing code after Medicare/Medicaid stops reimbursing for a service, payment for essentially no services, failure to document services provided, and billing of no-show visits.

#### For Further Information

For further information, please contact Charles R. Cuzydlo, JD, MSMS chief of Legal and Regulatory Affairs at (517) 336-5714 or ccuzydlo@msms.org. Or check out our Website at http://www.msms.org.

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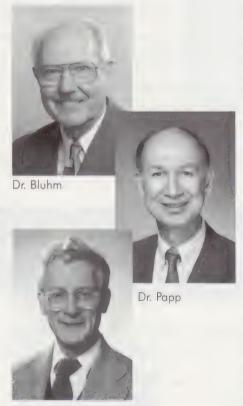
#### NEWSMAKERS



Ronald Davis, MD, recently was appointed North American editor for the British Medical Journal. Doctor Davis, a general prevention medicine practitioner from East Lansing, also is director of the Center for Health Promotion and Disease Prevention at Henry Ford Health System.



Carl F. Hammerstrom, MD, was presented with the Professional of the Year Award by the American Lung Association of Michigan (ALAM). This prestigious award the ALAM's highest honor—was presented to Doctor Hammerstrom because of his contribution to the planning and implementation of the city of Marquette's smoke-free ordinance. Doctor Hammerstrom, an internal medicine and respiratory medicine specialist, has been a longtime ALAM volunteer, serving on the State Board from 1973-80.



Dr. Weiss

Gilbert B. Bluhm, MD, FACP; John R. Papp, MD, FACP; John A. Penner, MD, FACP; and Joseph J. Weiss, MD, FACP, recently were presented with Laureate Awards from the American College of Physicians—American Society of Internal Medicine. The Laureate Award honors those Fellows and Masters of the College who have demonstrated by their example and conduct an abiding commitment and service to their community, their chapter, and the ACP-ASIM.

John D. Crissman, MD, a Detroit anatomic pathologist, recently was appointed associate dean of research and graduate programs at Wayne State University School of Medicine. Doctor Crissman has worked as professor of pathology at Wayne State, and as vice chair of the department of pathology for Henry Ford Hospi-

Woodrow A. Myers, Jr., MD, recently was elected 1999 chair of the Institute for Health Improvement in Southeast Michigan. Doctor Myers is a Detroit internist and director of Health Care Management at Ford Motor Company.

#### **NEW MEMBERS**

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

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Bernadine Wu, MD, Grosse Pte Daniel T. Yousef, MD, Saginaw Lelia Yu, MD, Flint Patrick Zietz, East Lansing Matthew Zimmie, East Lansing Michael Zydeck, MD, Wayne

#### **OBITUARIES**

Aeneas Constantine, MD, died on September 29, 1998. He was 85. Doctor Constantine graduated from the University of Michigan Medical School in 1937. He was a general practitioner in Harrisville for 60 years. Doctor Constantine was a member of the Lions Club, MSMS, and was past-president of the Alpena County Medical Society.

Reuben R. Licker, MD, died on September 30, 1998. He was 90. Doctor Licker graduated from the Wayne State University School of Medicine in 1935. He practiced obstetrics and gynecology in Port Huron. Doctor Licker served in the military during WWII from 1942-45. He was a member of the American Legion, the Lions Club, AMA, MSMS, and was past-president of the St. Clair County Medical Society.

E. Thurston Thieme, MD, died on October 6, 1998. He was 90. Doctor Thieme graduated from Harvard University Medical School in 1933. He served in the European Theater during WWII from 1942-45. Doctor Thieme went into private practice as a general surgeon at St. Joseph Mercy Hospital in Ann Arbor, where he later became Chief of the Department of General Surgery from 1940-65 and Chief of Staff from 1959-61. He also was a clinical professor of surgery at the University of Michigan. Doctor Thieme was a member of the American College of Surgeons, Central Surgical Society, Detroit Academy of Surgery, AMA, MSMS, and was past president of the Wastenaw County Medical Society.

#### DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Jack A. Brown, MD, 1005 W. Green St., Hastings, MI 49058

Action, Date Taken: 11-20-98; Reprimand; Fine— \$500.00

Reason: Violation of General Duty/Negligence

Name: Ralph J. Duman, MD, 590 S. Brys, Grosse Pte. Woods, MI 48236

Action, Date Taken: 11-20-98; License Suspended—1 mo.; Upon reinstatement, probation—6 mo.; Fine— \$5,000.00

Reason: Unethical Business Practices

Name: Kim M. Jaggers, MD, 49401 Pine Ridge Dr., Plymouth, MI 48170

Action, Date Taken: 10-27-98; Reprimand; Fine— \$1,000.00; Probation—2 yrs.

Reason: Failure to Meet Continuing Education Requirements

Name: Walter A. Robison, MD. 3125 W. Main St., Kalamazoo, MI 49006

Action, Date Taken: 11-02-98; Reprimand; Fine— \$1,000.00; Probation—2 yrs.

Reason: Failure to Meet Continuing Education Requirements

Name: James C. Shaya, MD, 7210 Ortonville, Rd., Ste. 205, Clarkston, MI 48346

Action, Date Taken: 10-26-98; Reprimand; Fine— \$1,000.00; Probation—2 yrs.

Reason: Failure to Meet Continuing Education Requirements

Name: Helen J. Scoblic, MD, 1060 S. Van Dyke, Ste. 400, Bad Axe, MI 48413

Action, Date Taken: 11-20-98; Reprimand; Fine—\$1,000.00

Reason: Negligence/Incompetence

Name: Bangarpet M. Balakrishna, MD, 2130 Birchwood Way, Bloomfield, MI 48302

Action, Date Taken: 11-17-98; License Summarily Suspended

Reason: Criminal Conviction

Name: Jonathan Rene, MD, 5810 Gratiot Ave., Saginaw, MI 48603

Action, Date Taken: 11-06-98; Reprimand; Fine—\$1,000.00; Probation—2 yrs.

Reason: Failure to Meet Continuing Education Requirements

Name: Cynthia A. Smith, MD, 5024 N. Royal Dr.,

Traverse City, MI 49684

Action, Date Taken: 10-26-98; Reprimand; Fine—\$1,000.00; Probation—2 yrs.

Reason: Failure to Meet Continuing Education Requirements

Name: Caesar A. Austin, MD, 17563 Greenfield Rd. #2, Detroit, MI 48235

Action, Date Taken: 12-02-98; License Suspended—minimum 6 mo. & 1 day

Reason: Failure to Meet Continuing Education Requirements

Name: James B. Johnson, MD, 844 Washington Ave., Ste. 700, Holland, MI 49423

Action, Date Taken: 12-02-98; License Suspended—minimum 6 mo. & 1 day

Reason: Failure to Meet Continuing Education Requirements

Name: Virginia M. Love, MD, 361 Greentree Lane, NE, Ada, MI 49301

Action, Date Taken: 12-02-98; License Suspended—minimum 6 mo. & 1 day

Reason: Failure to Meet Continuing Education Requirements

Name: Sinforoso S. Padilla, Jr., MD, 217 Lincoln St., PO, Box 469, Hart, MI 49420

Action, Date Taken: 12-02-98; License Suspended—6 mo.; Upon reinstatement, license limited; Probation—6 mo.; Fine—\$5,000.00

Reason: Drug Related

Name: Thomas M. Trueman, MD, 1111 North

Campbell, Royal Oak, MI 48067

Action, Date Taken: 12-02-98; License Suspended—minimum 6 mo. & 1 day; Fine—\$5,000.00

Reason: Substance Abuse



National Bural Health Association 22nd Annual Conference May 27-30, 1999 San Diego, California

#### EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

#### **MARCH 1999**

3-7, Radiology in the Desert: Practical Aspects of Radiology and Imaging. Location: Marriott's Camelback Inn, Scottsdale, AZ. Contact: Joyce Robertson, registrar, Department of Medical Education Professions, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: TBA.

8-12, Tutorials in Diagnostic Radiology. Location: Keystone Resort, Keystone, CO. Contact: Mayo Foundation, Rochester, Minnesota. Registrars, Mayo Foundation, Mayo School of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; fax (507) 284-0532. Approved for: 27 Category 1 credits.

10-11, Neurology Mini-fellowship. Location: Michigan State University Center for Clinical Neuroscience and Ophthalmology. Contact: Glen N. Ackerman, MD, MSU Center for Clinical Neuroscience and Ophthalmology, A-217 Clinical Center, MSU, East Lansing, MI, 48824; (517) 371-3472; fax (517) 371-5868. Approved for: 16 Category 1 credits.

12-14, Dermatology for the Non-Dermatologist. Location: Riviera Hotel & Casino, Las Vegas, NV. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

14-19, Current Clinical Applications and Challenges: The 21st Winter Psychiatry Conference. Location: The Yarrow Resort & Conference Center, Part City, Utah. Contact: Menninger Continuing Education, PO Box 829, Topeka, KS 66601-0829; or (800) 288-7377. Approved for: 33 Category 1 credits.

18, 38th Annual Maternal and Perinatal Heath Conference, presented by MSMS and Perinatal Association of Michigan. Location: Dearborn Inn, Dearborn. Contact: Sherry Fent at MSMS at (517) 336-5730 or sfent@msms.org. Approved for: 6.5 Category 1 credits.

21-23, Arrhythmias: Interpretation, Diagnosis & Management. Location: Westin Maui Resort, Maui, HI Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits. Joint Course with Coronary Heart Disease Update.

24, Coronary Heart Disease in Women: How Gender Differences Impact Quality of Care. Location: Auditorium I, School of Public Health, University of Michigan, Ann Arbor, 4:00-6:00 p.m. Contact: University of Michigan School of Public Health, Office of Development and External Relations (734) 764-8093; or (fax) (734) 763-5455. Approved for: 2 Category 1 credits

(each lecture in this series is worth 2 credits, please call for future listings.)

24-26, Coronary Heart Disease Update. Location: Westin Maui Resort, Maui, HI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits. Joint Course with Arrhythmias: Interpretation, Diagnosis, and Management.

25-27, Neurology for the Non-Neurologist. Location: Grand Beach Resort, St. Thomas, USVI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

25-27, Clinical Endocrinology for Primary Care Physicians. Location: Marriott's Beach Resort, Grand Cayman. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

26-28, Managing Respiratory Diseases. Location: Buena Vista Palace, Orlando, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO

80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

#### APRIL

8-10, Coronary Heart Disease Update. Location: Aruba, Hyatt Regency. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

8-10, Clinical Endocrinology for Primary Care Physicians. Location: The Westin Resort, St. John, USVI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

9-11, Arrhythmias: Interpretation, Diagnosis & Management. Location: Phoenix, AZ, Hilton Tapatio Cliffs Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

9-11, Neurology for the Non-Neurologist. Location: Marriott Casa Marina, Key West, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800)

421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 cred-

22-24, Hip & Knee Reconstruction: An Update. Location: The Pointe Hilton at Squaw Peak, Phoenix, AR. Contact: Mayo Foundation, Rochester, Minnesota. Registrars, Mayo Foundation, Mayo School of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; fax (507) 284-0532. Approved for: 14.5 Category 1 credits.

22-25, The American College of Physicians-American Society of Internal Medicine—Annual Session. (Pre-Session Courses April 20-21) Location: Ernest N. Morial Convention Center, New Orleans, LA. Contact: ACP-ASIM Customer Service, 190 N. Independence Mall West, Philadelphia, PA 19106-1572; or (800) 523-1546, ext. 2600. Approved for: 29 Category 1 credits.

23-25, Dermatology for the Non-Dermatologist. Location: Parc Fifty-Five, San Francisco, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-25, Managing Respiratory Diseases. Location: Las Vegas, NV, Bally's. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court,

Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

28, MSMS Center for Physician Education and Leadership presents "Negotiations Seminar" Location: Amway Grand, Grand Rapids, MI, 8:00 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org. Approved for: 6.5 Category 1 credits.

30-5/2, Dermatology for the Non-Dermatologist. Location: South Sea Plantation, Captiva Island, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

30-5/2, Clinical Endocrinology for Primary Care Physicians. Location: Hyatt Regency, New Orleans, LA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.



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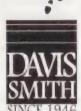
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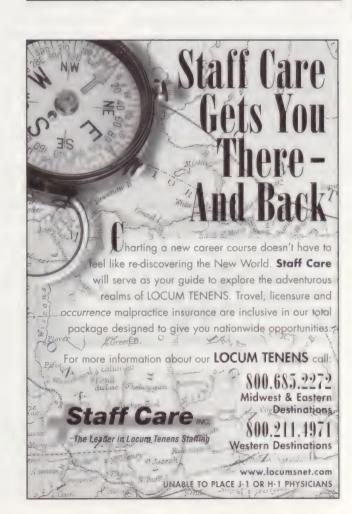
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#### March MSMS

- 4. MSMS CME Accreditation Committee Meeting. Location: Board Room MSMS Headquarters, East Lansing, MI, 1:30-4:30 p.m. Contact: Sarah Cressman at MSMS at (517) 336-5727 or scressman@msms.org.
- 5, "Trauma, Violence and Loss in Children—Teens: A Multicultural Perspective" Presented by Ele's Place—Speaker Ronald K. Barrett, PhD. Location: Marriott University Place, East Lansing, MI 8:00 a.m.-4:00 p.m. Contact: Ele's Place at (517) 482-1315.
- 5-6, MSMS Joint Section Meeting. Location: Ritz Carlton, Dearborn, MI. Contact: Judy Marr at MSMS (517)336-5744 jmarr@msms.org.
- 10, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing, MI, 10:00 a.m.-4:00 p.m. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.
- 10, Women Physician and Women Lawmakers Reception. Location: MSMS Headquarters, East Lansing, MI 4:30 p.m.-6:30 p.m. Contact: Greg Aronin at MSMS at (517) 336-5739 or garonin@msms.org.
- 11, MSMS Center for Physician Education and Leadership presents "Corporate Compliance: Fraud and Abuse." Location: U of M Kiva, Ann Arbor, MI, 6:00 p.m.-9:00

- p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.
- 11, Physician Practice Merger Seminar. Location: Amway Grand, Grand Rapids, MI. Contact: Kristen Sabec at MSMS at (517) 336-5769 or ksabec@msms.org.
- 15, MSMS Medical Business Specialist Program—"How to Improve Your Reception Skills." Location: St. Mary's Health Education Center, Saginaw, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org
- 16, MSMS Center for Physician Education and Leadership presents "E & M Tools, Tricks, and Helpful Hints for Surgical Specialists." Location: Dearborn Inn, Dearborn, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at 336-7581 (517)or imogyoros@msms.org.
- 16, MSMS Medical Business Specialist Program-"Successful Strategies for Patient Satisfaction." Location: Troy Marriott, Troy, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 jmogyoros@msms.org.
- 17, MSMS Center for Physician **Education and Leadership presents** "E & M Tools, Tricks, and Helpful Hints for Primary Care." Location: Dearborn Inn, Dearborn, MI, 8:00

- a.m.-11:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.
- 18, 38th Annual MSMS Conference on Maternal and Perinatal Health. Location: Dearborn Inn. Dearborn, MI. Contact: Sherry Fent at MSMS at (517) 336-5730 or sfent@msms.org.
- 18, MSMS Medical Business Specialist Program-"Successful Strategies for Patient Satisfaction." Location: MSMS Headquarters, East Lansing, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 23, MSMS Center for Physician Education and Leadership presents "Corporate Compliance: Fraud and Abuse." Location: Fetzer Center, Kalamazoo, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 23, MSMS/MICOA Closed Claim Review. Location: Battle Creek Health Systems, Battle Creek, MI. Contact: Kristen Sabec at MSMS at (517) 336-7587 or ksabec@msms.org.
- 24, MSMS Center for Physician Education and Leadership presents "Medicare + Choice." Location: Dearborn, Dearborn Inn, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.

- 24, MSMS CME Programming Committee Meeting. Location: MSMS Headquarters, The Atrium, East Lansing, MI, 3:00-5:30 p.m. Contact: Sarah Cressman at MSMS (517)336-5727 scressman@msms.org.
- 25, MSMS Center for Physician Education and Leadership presents "Medicare + Choice." Location: Days Inn, Grand Rapids, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 25, MSMS Medical Business Specialist Program-"Medical Terminology." Location: WMU-Regional Education Center, Grand Rapids, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517)336-7581 jmogyoros@msms.org.
- 25, MSMS/MICOA Closed Claim Review. Location: Flint, MI. Contact: Kristen Sabec at MSMS at 336-7587 (517)or ksabec@msms.org.

#### **APRIL**

- 6, MSMS Medical Business Specialist Program—"Introduction of CPT-4 Coding-The Basics!" Location: Troy Marriott, Troy, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 7, MSMS Committee on Aging. Location: MSMS Headquarters, East Lansing, MI, 3:00 p.m.-5:00

- p.m. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 7. MSMS Committee on State Legislation and Regulations. Location: MSMS Headquarters, East Lansing, MI, 2:00-5:00 p.m. Contact: Greg Aronin at MSMS at (517) 336-5739 or garonin@msms.org.
- 8, MSMS Medical Business Specialist Program—"Introduction of CPT-4 Coding-The Basics!" Location: WMU-Fetzer Center, Kalamazoo, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.
- 9, MSMS Committee of HMO Medical Directors. Location: MSMS Headquarters, East Lansing, MI, 12:00-2:00 p.m. Contact: Julie Lester at MSMS at (517) 336-5768 or ilester@msms.org.
- 13, MSMS Medical Business Specialist Program—"Introduction of ICD-9-CM Coding-The Basics!" Location: Hampton Inn, Warren, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at 336-7581 jmogyoros@msms.org.
- 15, MSMS Medical Business Specialist Program—"Introduction of ICD-9-CM Coding-The Basics!" Location: WMU-Fetzer Center, Kalamazoo, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.

- 15, MSMS Center for Physician **Education and Leadership presents** "Corporate Compliance: Fraud and Abuse." Location: Munson Medical Center, Traverse City, MI, 6:00-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 13, MSMS Medical Business Specialist Program—"How to Improve Your Office and Reception Skills" Location: MSMS Headquarters, East Lansing, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 21, MSMS Center for Physician Education and Leadership presents "Corporate Compliance: Fraud and Abuse." Location: Hampton Inn, Warren, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 27, MSMS Medical Business Specialist Program—"Medical Records & the Law." Location: St. Mary's Health Education Center, Saginaw, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 27, MSMS/MICOA Closed Claim Review. Location: Alpena, MI. Contact: Kristen Sabec at MSMS (517)336-7587 ksabec@msms.org.
- 28, MSMS/MICOA Closed Claim Review. Location: Gaylor, MI. Con-

tact: Kristen Sabec at MSMS at 336-7587 (517)or ksabec@msms.org.

28, MSMS Center for Physician **Education and Leadership presents** "Negotiations Seminar" Location: Amway Grand, Grand Rapids, MI, 8:00 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.

29, MSMS Medical Business Spe-Program-"Medical cialist Records & the Law" Location: Hampton Inn, Warren, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.

30, MSMS Board of Directors Meeting. Location: Ritz Carlton Hotel, Dearborn, MI, 3:00 p.m. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.

30-5/02, MSMS House of Delegates Meeting. Location: Ritz Carlton Hotel, Dearborn, MI. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.

#### **SPECIALTY SOCIETIES** MARCH

3, Michigan Chapter, American College of Surgeons, Issues Council. Location: Novi, MI. Contact: Carrie Brock at MSMS at (517) 336-7586 or cbrock@msms.org.

10, Michigan Allergy & Asthma Society Meeting. Location: Novi, MI. Contact: Melissa Wiegand at MSMS at (517) 336-7599 or

mwiegand@msms.org.

17, Michigan Society of Respiratory Care Pulmonary Rehab Committee Meeting. Location: MSMS Headquarters, East Lansing, 10:00 a.m.-2:00 p.m. Contact: Liz Foster at MSMS at (517) 336-7587 or lfoster@msms.org.

26-27, Michigan Society of Addiction Medicine. Location: Dearborn Inn, Dearborn, MI. Contact: Melissa Wiegand at MSMS at (517) 336-7599 or mwiegand@msms.org.

#### APRIL

2, Michigan Society of Respiratory Care Board Meeting. Location: MSMS Headquarters, East Lansing, MI 9:00 a.m.-4:00 p.m. Contact: Liz Foster at MSMS at (517) 336-7587 or lfoster@msms.org.

10, Michigan Association of Physician Assistants. Location: Traverse City, MI. Contact: Tom O'Keefe at MSMS at (517) 336-7589 or tokeefe@msms.org.

15, Michigan Ophthalmological Society. Location: Westin Hotel, Southfield, MI. Contact: Tom O'Keefe at MSMS at (517) 336-7589 or tokeefe@msms.org.

21, Michigan Dermatological Society Meeting. Location: Sacred Heart, Detroit, MI. Contact: Carrie Brock at MSMS at (517) 336-7586 or cbrock@msms.org.

22-23, Michigan Medical Group Management Association Spring Meeting. Location: Troy Marriott Hotel, Troy, MI. Contact: Melissa Wiegand at MSMS at (517) 336-7599 or mwiegand@msms.org.

23-24, Michigan Society of Anesthesiologists Annual Meeting. Location: Ritz-Carlton, Dearborn, MI. Contact: Tom O'Keefe at MSMS at 336-7589 (517)tokeefe@msms.org.

27-30, Michigan Society of Respiratory Care Spring Meeting. Location: Troy Marriott Hotel, Troy, MI. Contact: Liz Foster at MSMS at 336-7587 (517)or lfoster@msms.org.



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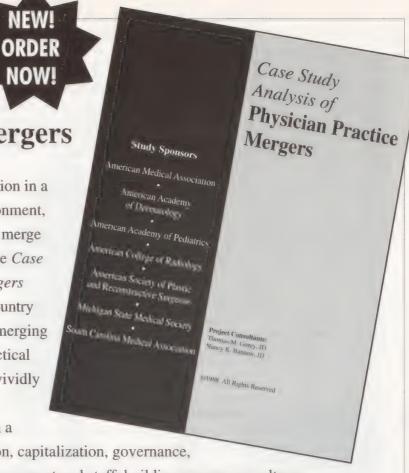


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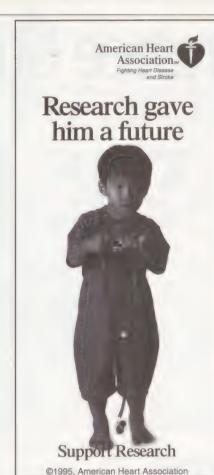
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#### Time to Contemplate?

A Look Ahead to an Action-Packed Year

By Cathy O. Blight, MD **MSMS** President



The long, cold, stretch of winter is upon us. Although the moderate fall temperatures raised our hopes that the winter chill would be lenient this year, the gray skies and dropping thermometers are here to stay. It's also the time of year when nothing exciting seems to be happening. It's that time, especially with the snow and ice, that the best thing to do is curl up in front of a fire with a good book.

But actually, it's a time when we should be planning for the busy year in front of us. Last year brought with it a whirlwind of activity. With the defeat of SB 104 (Prescriptive Privileges for Nurses) and, more recently, Proposal B (Physician-Assisted Suicide) our legislative successes were at an all-time high. But, as is often the case, more proactive thinking and planning is essential to insure continued success.

The End-of-Life Task Force recently was created in lieu of the defeat of Proposal B. This task force will work hard to develop cogent, compassionate alternatives to physician-assisted suicide. This month's cover story serves as in-depth coverage of end-of-life care, and provides the latest information to serve as a reference to physicians on the services MSMS and the AMA offer regarding this timely issue.

#### **Legislative Outlook**

MSMS' Governmental Relations Department has laid out an ambitious legislative plan to tackle upcoming issues on the state and national front. On the forefront are issues such as opposition to scope of

practice expansion legislation for allied and alternative health professionals; managed care accountability and utilization review; Medicaid solvency, reimbursement and timely payment; public health and safety issues; pain management initiatives; and Blue Cross Blue Shield of Michigan Reform, to name a few.

It is very important for physicians to stay involved in legislative issues both statewide and nationally. Due to the affects of term limits, we have 64 new members of the state House and Senate in Lansing to educate on issues near and dear to physicians both for our well being and that of our patients.

#### **Economics Matter**

As a result of sharing views with BCBSM about our original zero percent proposal, we are discussing with BCBSM efforts to address the utilization review audit function, prepayment utilization reviews, coding accuracy initiatives, a useful management program based on medical appropriateness, and procedures for which BCBSM is concerned about over-utilization.

MSMS' goal regarding BCBSM is to create programs that reward physicians who follow best practices and refine the monitoring activities for those who are truly practicing outside the bounds of appropriate care. BCBSM customers (large employers especially) are very concerned about the increasing costs of care, so it is to our advantage to be at the table to discuss areas of concern and develop collaborative strategies to address those areas.

#### **Education** is Tops

Education also is high on the agenda for 1999. The Center for Physician Education and Leadership had been working diligently to build comprehensive educational programming for physicians in Michigan. Programs created for physicians to enhance the practice-management side of medicine proved to be enormously successful in 1998.

To continue this trend, the education department at MSMS has continued to meet the ever-changing needs of physicians by offering seminars on such topics as: E & M Tools, Tricks and Helpful Hints; E & M Documentation Coding Guidelines for Physicians; 1999 Medicare Update; Practice Mergers; Corporate Compliance: Fraud and Abuse; Successful Contracting in a Managed Care Environment; Medicare + Choice; and Negotiations. In order to stay ahead in these turbulent times, I urge every physician to partake of this valuable educational experience.

Your office staff also may benefit from MSMS' new Medical Business Specialist Program. Upcoming workshops are designed to enhance the level of proficiency among your office staff of topics such as: ICD-9-CM Coding; Collections; Medicare Part B; and CPT-4 Coding.

So, despite the bitter cold, and the desire to stay cocooned indoors, it really isn't as much an inactive time as it is a time for contemplative review of the issues before us. It's a time to discuss and strategize for the coming year. Are you ready?

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Benjamin Disraeli, English statesman

# "People do not change with the times, they change the times."

P.K. Shaw, Author

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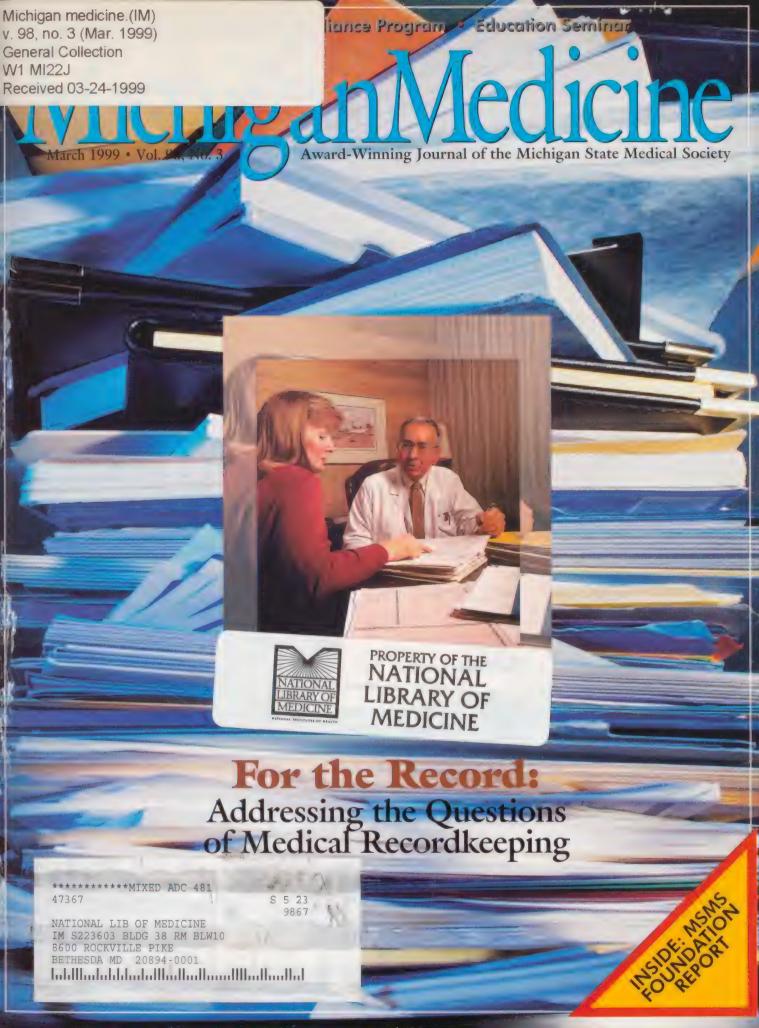


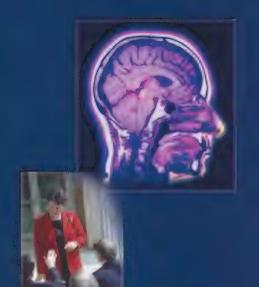
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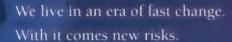
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#### COVER STORY



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#### For the Record: Addressing the Questions of Medical Recordkeeping

Am I required by law to provide a patient a copy of his or her medical record? Do you know how long records should be maintained or stored? Surprisingly, these are questions that many physicians have throughout the country—yet a comprehensive set of recommendations regarding records did not exist—until now. MSMS, in an effort to better serve its members, has created the only set of medical recordkeeping recommendations available. See how they can benefit you and your practice.

By Gregory Brusstar

#### FEATURES

**EDUCATION OUTLOOK** 

#### Hope is the bottom line: Leonard Marcus, PhD, brings passion to the table of health care negotiation

12

Two sessions on negotiations will be offered through the MSMS Physician Leadership Programs this spring.

By Stacy Lammers Sellek

SPECIAL FEATURE

#### Physicians' Spouses Caring Today for a Healthy Tomorrow

In recognition of Medical Alliance Month, the MSMS Alliance highlights their past successes and future

By Brenna Ellen Jackson

FOUNDATION UPDATE

#### 1999 MSMS Foundation Annual Report: Doctors, You Made a Difference!

Over the past year, the Michigan State Medical Society Foundation has had the pleasure of giving charitable funds to a variety of community-based programs promoting volunteerism and public health issues. By Robert Paxton, MD

March 1999 Volume 98, Number 3

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#### FEATURES

SPECIAL FEATURE

#### **Healing Hands and Generous Hearts: MSMS Recognizes Volunteer Efforts of Physicians**

March 30 is heralded as Doctors' Day, to honor the achievements of physicians who serve their profession above and beyond the call of duty and dedicate their careers to the care of patients and the advancement of the science and technology of medicine.

By Nate S. Pilon

CONTRACTING CLOSEUP

#### Compliance Programs: Do I Really Need One?

35

For the past several months, you have been reading and hearing about these and may have asked yourself "Why do I need a compliance program?"

By Charles Cuzydlo, JD

PHYSICIAN PROFILES

#### Physicians' Hobbies Enrich Lives: Art and Nature are Their Other Callings

37

Discover how the hobbies of three different physicians have enhanced and enriched not only their lives, but the lives of others as well.

By Ralph D. Ward

MSR SPOTLIGHT

#### MSMS' Answer People: MSRs Keep Physicians Informed

Not only do MSMS member service representatives carry information to doctors, they bring back to MSMS physician questions and concerns, and then provide timely answers and helpful resources.

By Colin Ford

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of **Michigan Medicine** and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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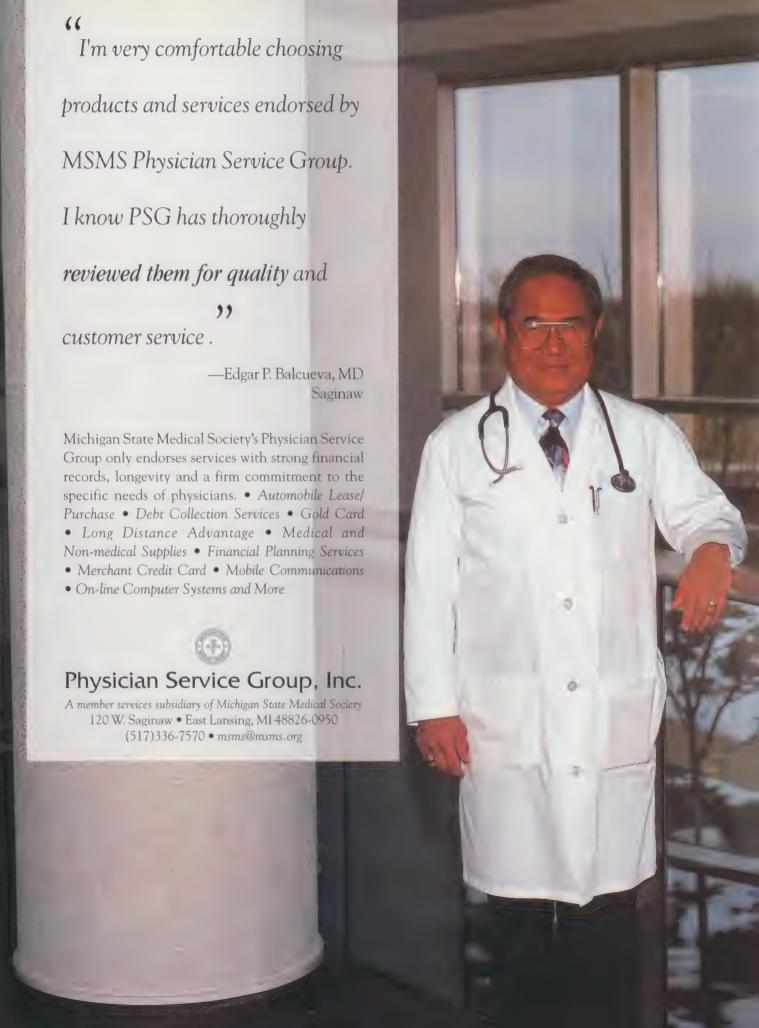
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# In Appreciation of a Distinguished Editor

Dear Colleagues

As chair of the MSMS Committee on Publications for the past six years, I have thoroughly enjoyed being a part of the development of the magazine. Over time, Michigan Medicine has evolved from its scientific journal roots, to the award-winning socio-economic magazine it is today. The tremendous success Michigan Medicine has experienced is due in large part to the fine guidance and astute professional judgement of its long-time editor, Judy Marr.

Judy has been closely involved with *Michigan Medicine* throughout her 30-year career at MSMS. Beginning in 1968 she served as Managing Editor and moved into her role as Editor not long after. Her warm, friendly disposition has provided a very necessary human touch to articles and interviews. Her sharp journalistic flair and creative eye have sharpened the magazine's focus and given it the "cutting-edge" style so important to a professional publication. Judy is a diligent reporter and top-notch editor, always searching for that great lead, yet retaining every element of a professional. Her perseverance and dedicated hard work have established *Michigan Medicine* as one of the most respected association magazines.

It has been a pleasure to work with Judy over the years, and I have a great deal of respect for the amazing body of work she developed here at MSMS. Recently, Judy assumed a new, important role as Executive Director of the MSMS Foundation, the philanthropic arm of our medical society. I am confident that she will bring the same good insights and creativity to her new position. The MSMS Foundation Annual report begins on page 19.

I would like to take this opportunity to thank her for all of the dedication and hard work she contributed to *Michigan Medicine* over the years, and, to wish her the best of luck in her new role. I hope she will always find happiness along the way.

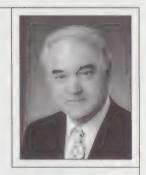
Sincerely, John H. McLaughlin, MD, Chair MSMS Committee on Publications



#### 182-Day Pre-Suit Notice Requirement

By Richard D. Weber, JD

MSMS Legal Counsel



Question: I received a document entitled "Notice of Intent To Sue" that did not specifically name me but included "all physicians at the clinic" who treated the plaintiff. Since I was one of the physicians who did treat the person named as the plaintiff, what should I do with respect to this notice? My treatment of this adult patient occurred more than one and one-half years ago. Would you please explain the notice provision, advise whether it has been upheld by the appellate courts and direct me on the best course of action.

**Answer:** The malpractice reform legislation that took effect April 1, 1994 contained a pre-suit notice requirement. Specifically, it provides that "a person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced." The act then provides that the notice given to the health professional or health facility shall contain a statement of at least all of the following: (a) The factual basis for the claim. (b) The applicable standard of practice or care alleged by the claimant. (c) The manner in which it is claimed that the applicable standard of care was breached by the health professional or health facility. (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care. (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice. (f) The names of all health professionals and

health facilities the claimant is notifying under this section in relation to the claim.

Last year the Michigan Court of Appeals upheld the constitutionality of this notice provision. MSMS filed an amicus curiae brief in support of the constitutionality which was instrumental in the court's decision.

In general, the Statute of Limitations applicable to adults is two years from the alleged malpractice occurrence. The Statute of Limitations is tolled, which means it does not run during the 182 days, if the Notice of Intent is given in compliance with the Notice of Intent Statute.

The Michigan Court of Appeals recently held that the Statute of Limitations is not tolled if the Notice of Intent does not comply with the statute. The statutory use of the word "shall" makes mandatory the inclusion of the names of all health professionals notified. The Court of Appeals held that a description in the notice is not a name as required by the statute. Therefore, the plaintiff was held to have failed to comply with the specific notice requirement and, therefore, the Statute of Limitations was not tolled. In that case, the Court of Appeals reversed the Trial Court and held that the complaint was barred by the Statute of Limitations. If the Notice of Intent had properly named the health professionals, the Statute of Limitations would have been tolled and would not have expired.

Based upon this recent Court of Appeals decision, it appears that the Statute of Limitations has not been tolled. Unless the plaintiff's attorney corrects the deficient Notice of Intent To Sue, it is probable that the suit will be barred upon expiration of two years after the date the alleged malpractice occurred with respect to your treatment of the patient.

What you should do in this instance is the same as what you should do in any instance where you receive a complaint or other legal document. The Notice of Intent To Sue should be immediately forwarded to your professional liability insurance carrier. If you are uninsured, the notice should be immediately forwarded to your attorney. The Statute of Limitations and related legal issues discussed in this column can then be applied to the specific facts in your case. If a complaint is filed based upon the existing Notice of Intent, it is likely that you will have a valid Statute of Limitations defense and the case will be dismissed against you.

The author is senior partner with Kerr, Russell, and Weber, Detroit, ()5(

Editor's note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Kristen Lare, managing editor, P.O. Box 950, East Lansing, MI 48826-0950.



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#### EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

#### **APRIL**

8-10, Coronary Heart Disease Update. Location: Aruba, Hyatt Regency, Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

8-10, Clinical Endocrinology for Primary Care Physicians. Location: The Westin Resort, St. John, USVI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

9-11, Arrhythmias: Interpretation, Diagnosis & Management. Location: Phoenix, AZ, Hilton Tapatio Cliffs Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

9-11, Neurology for the Non-Neurologist. Location: Marriott Casa Marina, Key West, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

13, 20 Bar-Levav Educational Association Ongoing Seminar Series "Treating stubbornness: The "power" of those with a sense of powerlessness." Location: 3000 Town Center, Suite 1275, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

22-24, Hip & Knee Reconstruction: An Update. Location: The Pointe Hilton at Squaw Peak, Phoenix, AZ. Contact: Mayo Foundation, Rochester, Minnesota, Registrars, Mayo Foundation, Mayo School of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; fax (507) 284-0532. Approved for: 14.5 Category 1 credits.

22-25, The American College of Physicians-American Society of Internal Medicine—Annual Session. (Pre-Session Courses April 20-21) Location: Ernest N. Morial Convention Center, New Orleans, LA. Contact: ACP Communications Dept., 190 N. Independence Mall West, Philadelphia, PA 19106-1572; or (800) 523-1546, ext. 2653. Approved for: 29 Category 1 credits.

23-25, Dermatology for the Non-Dermatologist. Location: Parc Fifty-Five, San Francisco, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500,

Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-25, Managing Respiratory Diseases. Location: Las Vegas, NV, Bally's. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

30-5/2, Dermatology for the Non-Dermatologist. Location: South Sea Plantation, Captiva Island, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

30-5/2, Clinical Endocrinology for Primary Care Physicians. Location: Hyatt Regency, New Orleans, LA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

#### MAY

4, 11 Bar-Levav Educational Association Ongoing Seminar Series "How to develop a physician-like attitude in non-medical psychotherapists." Location: Town Center, Southfield, MI. Contact: Lester

Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

14-16, Managing Respiratory Diseases. Location: Hilton Resort, Hilton Head, SC. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

14-16, Neurology for the Non-Neurologist. Location: Las Vegas, NV, Bally's. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

17-19, Mayo Clinic Nicotine Dependence Seminar: Counselor Training & Program Development. Location: Siebens Medical Education Building, Rochester, MN. Contact: Mayo School of Continuing Medical Education, 200 First St. S.W., Rochester, MN 55905; (800) 284-0532; or fax (507) 284-0532. Approved for: 24 Category 1 credits.

18, 25 Bar-Levav Educational Association Ongoing Seminar Series "The moral values of the psychotherapist: Can they, and should they, always be kept out of the therapeutic process?" Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

19-20, Neurology Mini-fellowship. Location: Michigan State University, East Lansing, MI. Contact: Glen N. Ackerman, MD, A-217 Clinical Center, Michigan State University, East Lansing, MI 48824; (517) 371-3472; or fax (517) 371-5868. Approved for: 16 Category 1 credits.

#### JUNE

1, 8 Bar-Levay Educational Association Ongoing Seminar Series "When intensive psychotherapy has ended: A look at the relationship of ex-patients with their extherapists." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

11-13 Managing Respiratory Diseases. Location: Parc Fifty-Five, San Francisco, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

15, 22 Bar-Levay Educational Association Ongoing Seminar Series "'Nervous habits': What they mean and the treatment they require." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

17-19 Issues in Women's Health. Location: Hyatt Regency, Grand Cayman. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

25-27, Coronary Heart Disease Update. Location: Sheraton Fiesta Beach Resort, South Padre Island, TX. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.



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# Hope is the bottom line.

Leonard Marcus, PhD, Brings Passion to the Table of Health Care Negotiation

By Stacy Lammers Sellek

ou scratch my back, and I'll scratch yours. In the health care arena, this may seem like Greek to many physicians and managed care organizations, but not for long. Leonard J. Marcus, PhD, a pioneer in the field of conflict resolution and negotiation in health care, is translating this idea for both sides and affecting positive change along the way. Marcus will travel to Michigan to present two sessions of his course on negotiations through the MSMS Physician Leadership Programs this spring.

Hear Doctor Marcus at MSMS Leadership Conferences:

- · Wednesday, April 28 in **Grand Rapids**
- Wednesday, May 12 in Dearborn

The founding director of the Program for Health Care Negotiation and Conflict Resolution at the Harvard School of Public Health. Doctor Marcus has examined the multiple facets of health care negotiation for the past 12 years. In his research and teachings of health care negotiations, he has found the following truth: collaborative efforts lead to success on both sides.

When he presents to Michigan physicians this spring, Doctor Marcus plans to lead physicians through what he calls "The Walk in the Woods," which is an analogy for the entire negotiation process. "There's now a recognition in health care that each party must bring collaborative efforts to the table," he explains. "Physicians and health care administrators must look at multidimensional problem-solving in order to succeed."

Based on this philosophy, his latest book, Negotiation Wisdom: The Walk in the Woods (Jossey-Bass), takes each party through the following four steps in negotiations:

- Step 1: Self interests (what each party wants, hopes to gain, and is concerned with in the negotiation)
- Step 2: Enlarged interests (what is each

- party's new understanding of its self interests)
- Step 3: Enlightened interests (creative process of listing ideas to solve the conflict or to reach a common ground)
- Step 4: Aligned interests (sorting through the ideas to decide on an agreement)

Doctor Marcus is passionate about his work, and he strongly believes the crux of his teachings and work is hope. "The bottom line in the course is that I want each party to leave with hope," he

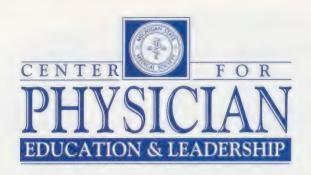
says. "Hope represents what can be accomplished and attained with compromise and the creation of a working balance."

#### An Unfulfilled Need

When he began working and developing the field of conflict resolution and negotiation, he realized that it was practically a non-existent profession. Part of the reason he decided to pursue it was the fact that he saw a need for strong negotiation skills in health care, which had previously been undeveloped.

"No one was doing this kind of work back in the '80s when I started," he says. "The connection between this field and health care had not yet been made, and I thought, 'Why isn't anyone talking about this?""

Doctor Marcus is making that connection both nationwide and world wide, having studied and developed plans for health care negotiations in the Middle East, Asia, and Eastern Europe. In America, many changes in health care have taken place over the last decade particularly the shift from high-cost specialty services to primary care. Doctor Marcus realized that America's health care needs and concerns would not wait for physicians and administrators to figure out how to adapt and move



forward. He has said that the time is now for health care reform, and tomorrow we will be able to say that all over again.

Doctor Marcus believes that in health care negotiation, parties and mediators must develop a balance within their respective outlooks. "We must examine the short term because things are changing so quickly," he says. "But we can't lose sight of the long term."

#### Reform and Resisitance

Evolution is a word that Doctor Marcus likes to use. He points out the evolution of man and the evolution of technology (particularly the Internet), for example, in mediation sessions because it encapsulates the nature of health care as he sees it. "Conflicts often stem from the contest between reform and resistance," he says. "Those who benefited in the old days strive to hold on, while those seeking to create new ways fight for change. But this conflict benefits no one because it doesn't allow for progress or success to take place."

In order to maintain a high quality of patient care and management in this country, physicians and health care administrators must be proactive. How can this be done within a managed care environment? Doctor Marcus' answer is this: WIN. An acronym for "Whole Image Negotiation," WIN refers to the framework for negotiating that fits the current changes and challenges of health care. "Whole" refers to the big picture and shared interests of each party. "Image" refers to the creative development part of negotiation that requires us to conceive of something that is not readily apparent.

The title of Doctor Marcus's first book, Renegotiating Health Care (Jossey-Bass) is also the name of the regular column he writes for the AMNews. He has received funding from many organizations, including the W.K. Kellogg Foundation, the Robert Wood Johnson Foundation, William and Flora Hewlett Foundation, and the National Center for Dispute Resolution. He

completed his doctoral work at The Heller School of Brandeis University.

#### **MSMS Leadership Conferences**

- Wednesday, April 28 from 8:00 a.m. 4:00 p.m. at the Amway Grand in Grand Rapids
- Wednesday, May 12 from 8:00 a.m. 4:00 p.m. at the Dearborn Inn in Dearborn

The course fee is \$235 for MSMS members and \$300 for non-members. For more information, contact Mary Jensen at 517-336-5706 or miensen2@msms.org.

The author is MSMS Foundation liaison.

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#### **Lansing Ophthalmology**

**Executive Committee** C/O Charles Dobis 2001 Coolidge Road East Lansing, MI 48823

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# March is Medical Alliance Month

Physicians' Spouses Caring Today for a Healthy Tomorrow

#### By Brenna Ellen Jackson



erhaps you've wondered what your spouse does when he or she leaves you to spend a few hours with your county medical society Alliance. You might be intrigued to learn that the Alliance is working to support the goals of your county and state medical society, as well as the AMA. He or she may be devoting time, which you don't have to spare, working on issues near and dear to your heart. And, having a little fun in the process.

Through hosting candidate fundraisers, distributing literature, and manning phone banks,

Alliance members worked tirelessly to help get out the vote that elected Supreme Court Justices Taylor and Corrigan, the MSMS endorsed candidates. We also worked with the medical society to help defeat the nurse practitioner prescribing bill as well as other scope of practice legislation.

In keeping with our tag-line "physicians' spouses caring today for a healthy tomorrow," our county Alliances conduct a multitude of health projects. These

projects represent a hands-on way that our volunteers provide service to their communities. Diverse projects tailored to meet specific county needs range from immunization education, to "adopt a shelter" programs, to the SAVE (Stop America's Violence Everywhere) initiative.

Donating to the AMA-Foundation also starts at the local level. Each county Alliance has a chairperson, who coordinates AMA-Foundation local fundraising. Funds gathered are used in the following ways:

◆ Education: Support for special projects to enrich the training of medical students and for



Members of the Chippewa County Alliance joined with MSMS Alliance members Sue Heyka of Petoskey (back row, 4th from left), and Sue Addy of East Lansing (back row, 5th from left) to Make a Difference in the Upper Penninsula.

> Members of the Ingham County Medical Society Alliance are pictured at a luncheon with a basket full of personal care items they collected for distribution to a Lansing-area shelter on "Doctors and Their Families Make a Difference Day."





(left to right) Jay Kommareddi, MSMSA president-elect; Phila Chidiac, co-president of teh Wayne County Alliance; and Lila Esfahani, president of MSMSA gather at a dinner.

assistance to medical students with financial need

- ◆ Research: Support for laboratory and clinical medical research
- ◆ Service: Awards for innovative community health initiatives, outstanding health educators within the physician community, and to honor physicians who promote high standards of ethics and professionalism



Lila Esfahani, president of MSMSA and James K. Haveman, director of the Michigan Department of Community Health, at the news conference at the State Capitol for SAVE Day and Make a Difference Day Kick-off.

By now, you may be rather proud of your spouse's work with the medical society Alliance, knowing that he or she is working hard to support your profession. Over 1,700 spouses have joined our cause in the state of Michigan. And, if your spouse hasn't joined the Alliance, we'd be glad to welcome them into our group. Any

physician's spouse is eligible to join. To learn the name of the contact person in your county call Liz Foster, MSMSA executive director MSMS at (517) 336-7587 lfoster@msms.org.

The author is AMA-Foundation chair for the MSMSA.



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access to services from the bank and our affiliates, including portfolio management, trust services, financial counseling, brokerage services and private banking. For more information about the National City Private Client Group, call Newton Kimberly at 1-800-243-7274.

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# 1999 MSMS Foundation **Annual Report**

Doctors, You Made a Difference!

By Robert E. Paxton, MD

ver the past year, the Michigan State Medical Society Foundation has had the pleasure of giving charitable funds to a variety of community-based programs promoting volunteerism and public health issues. Because of MSMS members' generous donations to such organizations as the Specialized Language Development Learning Center, Michigan Fitness Foundation, and the Wayne State University Institute of Gerontology, public health issues are being promoted throughout Michigan.



Robert E. Paxton, MD

The Foundation Board of Trustees extends its sincere appreciation to those who have made donations to these charitable organizations and have supported its annual and on-going campaigns—the Annual Golf Classic, Doctors and Their Families Make a Difference, and the Legacy Campaign.

Your MSMS Foundation depends on you, MSMS members and your families, to provide contributions that enable increased support for our Michigan communities.

In 1998 The MSMS Foundation Board awarded grants to the following organizations:

SLD Learning Center, Inc., Grand Rapids and Kalamazoo-Specialized Language Develop-

Tammy Peck and her son Andrew, both of Jenison, know about the physical and mental challenges that accompany dyslexia. Andrew was diagnosed with the disorder nearly three years ago when he was 8 years old, and thanks in part to a grant

from the Foundation to SLD Learning Center. Andrew is catching up to the reading level of his current classmates.

The center, incorporated in 1974, provides dyslexic children with one-on-one attention from tutors, a luxury that many schools cannot afford. SLD services are available to dyslexics of all financial backgrounds, and with the help of grants from organizations like the MSMS Foundation, are able to administer scholarships



SLD Volunteer Linda Doering takes a break from tutoring her pupil, Chad.

to those in financial need. The tutoring is free. and the tutors—trained volunteers—are not paid. The Grand Rapids School System is a joint administrator of the program.



Governor's Council Chair Charles T. Kuntzelman (left) presents an award to James Jackson, who accepted the Female Amateur Athlete of the Year Award on behalf of winner Stacey Thomas.

#### Michigan Fitness Foundation, Lansing Governor's Council on Physical Fitness, Health and Sports

The awards given by the Michigan Fitness Foundation—presented to Michigan citizens who put forth exceptional efforts in helping others be more physically active—symbolize a commitment to the well-being of our community at large. Established in 1994, MFF was designed to expedite the Governor's Council policies and programs, and provide a broader funding base for its initiatives.

The grant awarded by the MSMS Foundation will help to ensure that the following goals of the MFF are consistently met:

· Promoting awareness among Michigan citizens of the health-related benefits of physical activity

- Encouraging cooperation and collaboration among those who promote and sponsor programs devoted to health and physical activity
- Recognizing exemplary programs of physical
- Fostering the development of model or demonstration programs

Institute of Gerontology, Wayne State University-"Issues in Aging"

Since 1987, WSU's Institute of Gerontology has made strides in researching such issues as dementia, cancer in the elderly, and clinical gerontology assessments and interventions, by offering continuing education programs for physicians, nurses, psychologists, nursing home administrators, and social workers.

Thanks to a 1998 grant from the MSMS Foundation, the Institute was able to promote health initiatives and studies on the elderly through its 11th Annual Continuing Education Program on Issues in Aging. The program included three days of discussion and workshops on such topics as psychosocial care for the elderly, interventions in family care-giving, applications of cognitive aging research, interventions with older problem drinkers, structural brain abnormalities in late-life depression, and many more.

#### **MSMS Foundation Legacy Program**

During the 1998 MSMS House of Delegates meeting, the Foundation launched its new Legacy campaign, a program for planned giving that provides you, MSMS members, with the opportunity to leave your legacy for generations to come. Your name and the names of your honored loved ones will stand for generations as a symbol of benevolence and purpose through your gift to the Foundation.

"Doctors and **Their Families** Supporting Michigan Communities"

The Legacy program presents a variety of ways for you to leave a gift through MSMSby gifts of cash, retirement plans, bequests, life income gifts, gifts of real estate, or gifts of life insurance or stock. Also, your gift to the MSMS Foundation qualifies you for the highest possible deduction for charitable contributions under federal law. Therefore, a contribution to the Foundation can help you minimize your income tax burden while you support health promotion programs across Michigan.

Members who make a major gift through the Legacy program before May 1, 1999 will become charter members of the MSMS Foundation Legacy Club, and will be recognized at the 1999 House of Delegates meeting. For further information on the Legacy program, contact Judy Marr at (517) 336-5744 or jmarr@msms.org.



Daniel H. "Stormy" Johnson Jr., MD (AMA Past Pres.), Terry Roote, Edward J. Rutkowski, MD (Traverse City), Fran Gingras, winners of the 1998 MSMS Golf Classic.

#### 1999 MSMS Foundation Golf Classic

Monday, May 17, Country Club of Lansing Join your colleagues and friends of medicine for action and fun while you help expand your MSMS Foundation's ability to support community health promotion projects. Play in the 7th Annual MSMS Foundation Golf Classic Monday, May 17 at the beautiful Country Club of Lansing. Invitations are being mailed to former participants. To sign up, contact Foundation Executive Director Judy Marr at (517) 336-5744 or jmarr@msms.org.

#### The Mission of the **MSMS** Foundation

Michigan State **Medical Society** Foundation is a nonprofit charitable organization sponsored by the Michigan State Medical Society. Its purpose is to advance the field of health for the public good.

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#### MSMS Foundation 1998 Contributors

The MSMS Foundation thanks the individuals and organizations below for their generous contributions during the past year. Their donations made it possible for the Foundation to continue supporting worthy community-based health promotion projects all across the state.

Send your contribution today to your MSMS Foundation—the only statewide, physiciansponsored, public charity—at 120 W. Saginaw Street, East Lansing, 48823. Find the MSMS Foundation on-line at http://www.msms.org/ msmsf.

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# For the Record:

# Addressing the Questions of Medical Recordkeeping

By Gregory Brusstar

ven seemingly simple, practical questions about medical records have defied ready answers.

How long should I keep my medical records after I retire or sell my practice? Am I required by law to provide a patient with a copy of his or her medical record? If I sell the practice, what should I do with the records? If I'm faced with storing the records, how (in what medium) should I store them? What companies can provide medical records storage or imaging services?



lthough the questions are straightforward, the answers are often ambiguous because of the mixed bag of issues related to proper medical record keeping. The issues of physician responsibility, continuity of care, and patient interests are clouded by statutes of limitations, potential lawsuits, managed care plan requirements, and technological advances. Indeed, the only thing black and white about a medical record is its appearance.

The American Medical Association (AMA) offers surprisingly little practical guidance to the physician looking for advice on medical record keeping. State laws address the narrow issues of appropriate access to and release of information.

Faced with physician questions and frustration with medical records issues, the Michigan State Medical Society published its own "recommendations" earlier this year. Titled, Medical Records Information, this concise 30page information booklet assembles the best thinking of the MSMS Risk Management Committee, the MSMS Board of Directors, attorneys specializing in medical issues, and the AMA. The booklet is free of charge for MSMS members and \$24.95 for non-members.

"Our committee compiled this document in response to the most frequently asked medical records questions at MSMS," said Edwin H. Gullekson, MD, a member of the Risk Management Committee. "Obviously, some questions don't have a clear answer, but we've compiled available information and made recommendations in some areas. Every physician should have a copy."

Thomas C. Payne, MD, chair of the Risk Management Committee emphasizes that these are practical and educational recommendations only, and they should not be regarded as standards of practice or legal advice.

"These are issues that physicians and patients struggle with," Doctor Payne said. "They reflect considerations of fairness and risk management."

"We worked hard on the document and its recommendations. This is the first time we have an accurate source of information about medical records that physicians can turn to."

MSMS Manager of Risk Management Peggy Galloway, RN, MHA, helped frame the issues and compiled much of Medical Records Information. "There are many questions regarding how long records should be kept, what to do with them when a practice closes or changes hands, how to recover costs of storing and copying records, and how they can be located years later," Galloway said. "Also, changing practice patterns are a fact of life, and physicians do not practice in one location for a lifetime as they used to. This means that there are many more practices closing and changing hands, or owned by corporate entities than there were 'in the old days.' "

Also, not every physician handles their records in the same way. Thomas R. Berglund, MD, MSMS Board member, and member of the risk management committee explains. "Physicians do all kinds of things with their records. They give them to office staff to handle, sometimes widows are stuck with them, and sometimes they're transferred to another physician."

#### How Long Should I Keep My Medical Records?

Short answer: Medicare and Medicaid records must be maintained for six years. There is no Michigan law governing the length of time a medical record must be kept, says MSMS Legal Counsel Richard D. Weber. Practically speaking, medical records for competent adults should be kept for at least seven years and longer than that for minors, according to the MSMS recommendations.

Long answer: With respects to minors, records should be kept at least seven years or until the 10th birthday for treatment after April 1, 1994; until the 15th birthday for treatment after October 1, 1986; and until the 19th birthday for

"These are issues that physicians and patients struggle with. They reflect considerations of fairness and risk management."

-Thomas C. Payne, MD

treatment prior to October 1, 1986. To protect the physician from litigation, the statutes of limitations must dictate the length of time to retain medical records. With respect to injuries involving a minor's reproductive system, such records must be kept until the minor's 15th birthday. Other complicating circumstances such as fraudulent concealment by the physician, incompetence of the plaintiff and, regarding treatment prior to April 1, 1994, wrongfully leaving a foreign object in the body extends the statute of repose. Therefore, the safest course would be to "maintain records indefinitely." That is, for the rest of your life.

#### Am I required by law to provide a patient with a copy of his or her medical record?

Short answer: Yes.

Long answer: Michigan law provides that competent adults have a right to full access to their medical records. The ownership of the paper upon which the records are written must be distinguished from the information itself. The document containing the information belongs to the physician. The patient, however, is entitled to have that information made available for inspection and copying.

"I don't think physicians fully understand the patient's right to their record," Doctor Berglund says. "And sometimes physicians might hesitate because of the size of a patient's record. Twenty years of information can be a lot. This is where the physician should use judgment as to what's important. You hone the information down and send only the useful information," explains Doctor Berglund.

"Most physicians realize that they have an obligation to medical record information to patients, but it's important that physicians know that the patient has a right to a copy of the record, and not the record itself. The record is the physician's property. Using judgment and providing pertinent parts of the medical record is perfectly OK," says Thomas E. Stone, MD, member of the Risk Management Committee.

All record requests should be in writing. If a patient in your office requests his or her records, require the patient to fill out and sign a release form. Mail a release form to those making telephone requests. The original record should never be released.

Here are the MSMS recommendations regarding appropriate copying fees:

- Physicians must comply as promptly as possible after receiving a valid written authorization
- Records must be available during business hours for inspection/examination with supervision

#### What is the appropriate copying fee for medical records?

The law requires copying charges to be reasonable. However, the word "reasonable" is not defined. MSMS recommends that a charge of up to 20 cents per page is reasonable, but consideration should be given to a lesser charge if multiple pages are copied.

- State law requires medical record copying charges to be "reasonable" (MSMS recommends up to a 20 cent per page charge)
- ◆ A similar fee may apply to requests for faxed records
- Professional courtesy may be recognized in providing records to other physicians for the purpose of facilitating continuity of care
- ◆Physicians may charge actual costs of copying x-rays, EEGs, EKGs, and imaging records
- Postage fees may be added to the charge as well



- ◆ Fees may be charged in advance of the work
- ◆ Physicians may not refuse to copy records because a patient's account is delinquent
- ◆ If a physician is asked to give an opinion, a reasonable fee for professional services may be charged at the discretion of the physician

#### If I sell my practice, what should I do with the medical records?

Short answer: Sell them with the practice, transferring them to the new provider, who will serve as custodian of the records. The sales contract, drafted by legal counsel, should include a delineation of responsibilities for medical records retention and accessibility.

Long Answer: "In the contract, make sure the buyer has responsibilities for the medical record," Galloway says. "When you are in possession of medical records you have responsibilities, and there are certain expenses associated with it. This is one of the advantages of selling a practice rather than closing it."

After a practice is sold, the parting physician should inform patients of the move or retirement. State the date you will be discon-

Notify your county medical society if you retire or sell your practice of the location of your records

If you are retiring or selling your practice, please notify your county medical society and give the name, address, and phone number of your medical records "custodian" so patients can locate their records and request a copy.

In many cases, physicians choose to be the custodian of their own records. If a practice is sold, the physician who purchased the practice will probably become the records custodian. The records must be accessible to patients.

tinuing care. Then state how and where medical records will be stored, how confidentiality is assured, how to request a transfer of records, and the length of time records will be maintained prior to destruction.

Next, to facilitate patient inquiries, notify the county medical society of the identity of the record custodian and the method of requesting a copy of records. County medical societies, especially in heavily populated areas, keep this information on file.

"We encourage physicians to let patients know where their records can be found," said Shirley Montagne, executive director of the Macomb County Medical Society. "We find that some physicians don't send letters to their patients. Then the patients call us."

MSMS recommends the following actions when a practice is sold to a successor:

- ◆ The physician who is purchasing the practice should assure that the patients' medical information is protected and accessible to appropriate individuals
- ◆ The records should be maintained for a minimum of seven years for competent adults and longer for minors
- ◆ Patients should be able to obtain copies of their records or transfers to other physicians upon signing a valid authorization to release information
- ◆ The retiring physician will have access to the records as necessary for defense in a medical liability action
- The retired physician and the patients should be notified in the event records are moved to another location or destroyed

#### If I'm faced with storing my medical records, how (in what medium) should I store them?

Short answer: MSMS does not recommend a preferred method in which records should be stored. But in general, there are three options

#### Some companies that offer microfilm or digital imaging

These are just a few companies that can image medical records on microfilm, CD-ROM, or both.

Graphic Sciences, Inc., Royal Oak, MI microfilm only. (248) 549-6600

Lason, Inc., Lansing, MI microfilm and CD-ROM. (800) 968-6818

Dictation East, Inc., Lake Park, FL CD-ROM only. (561) 842-5110

ProVisual Data Systems, Lexington, KY CD-ROM only. (888) 285-6601

for medical records storage: in hard-copy form, on microfilm, or digitally on CD-ROM.

Long answer: Many of the problems associated with storing medical records—space, expense, and custodial care—will eventually be eliminated when physicians use predominantly computerized medical records. A small box of CD-ROM disks will store records for thousands of patients. But until the computerized record is the norm, many physicians will have to decide how to archive their paper records.

MSMS offers these recommendations for security and storage of records:

- ◆ Records should be stored using a filing system and storage area that safeguards the records form loss, tampering, defacement, or use by unauthorized persons
- Secured methods would include storing the records in locked cabinets or rooms
- During on-site review of a record by a requester, measures should be taken to ensure the record is not tampered with

- A record should not be removed without a subpoena accompanied by a court order or a release signed by the patient
- A sign-out system should be used when a record is removed from storage to ensure it can be located at all times

Selecting the media in which to archive medical records will involve a cost-benefit analysis of the options. Do you archive in hard copy at a fairly low, but continuous monthly storage expense? Do you have your records imaged and put on microfilm, which will involve a significant up-front cost but no monthly storage cost, with the minor inconvenience of manually searching for and copying records when necessary? Or do you put your records on CD-ROM, which is the most expensive option but the most convenient if you need regular file access and printing capabilities?

Another ambiguous issue surfaces if a physician chooses to archive medical records on microfilm or CD-ROM: whether or not to destroy hard-copy medical records after the files are imaged. MSMS' Medical Records Information provides no recommendations, but offers this bit of information: There are no statutes governing the acceptability of the transfer of records to electronic storage media. In the absence of statutes, case law is the determinant of the acceptability of this storage media, and case law in Michigan does not exist on this issue.

#### What companies can provide medical records storage or imaging services?

Short answer: Many. Find them, talk to them, get several quotes, and then decide. In the decision process, consider how long you'll need to keep the records, how often you'll need to access and copy records, and whether you are willing to access them yourself or you want someone else to handle the task when needed. Long answer: MSMS recommendations do not address the issues of selecting a company to use



#### Computerized medical records software companies

These companies offer software for computerized medical records. The software has been reviewed and approved by MICOA (Mutual Insurance Corporation of America) for computerized patient records and patient information systems.

Applied Productivity Systems Berdy Medical Systems, Inc. Capmed Division of Electronic Healthcare Systems Chartcare, Inc. Clinical Networx, Inc. Crowell Systems EMC, Inc. Epic Systems Corp. HealthCare Data, Inc. **HealthMatics** Hub Computer Medical Systems, Inc. The ISYS Group, Inc. Masterpiece Medical MedCom Information Systems, Inc. MedicaLogic, Inc. Medic Computer Systems, Inc. PAL/MED Services, Inc. Physician Micro Systems, Inc. Q.D. Systems

For more information about the software these companies offer, call Elizabeth Bollwahn at MICOA, (800) 748-0465, or find their Websites by going to through the MICOA Website (http://MICOA.com). Once you are in MICOA.com, click on Liability Risk Management, and then Computerized Patient Records Software.

for storage or imaging. But this reporter located several companies and talked to them about their services. To find these companies, use the telephone book's Yellow Pages (look under Storage and Micrographics), the Internet, and recommendations from colleagues and hospital medical records departments. Companies that can provide storage and imaging services range from the low-tech self-storage units to high-tech digital imaging.

The low-tech option — storing medical records in a self-storage unit — is generally for those who believe patient demand for record access will be minimal. Care must be taken, of course, to ensure that the records are secure and that they will last in good condition for the proper amount of time (seven years for adults and longer than that for minors). However, few companies offer a "temperature controlled" environment (this means heated in winter, but not air-conditioned in summer), which a physician may select in order to extend the shelf-life of the records. Even fewer hard-copy storage companies offer record retrieval services, which may be a convenient service for you. One particular company that offers hardcopy archiving and retrieval services is Safe Records Center, Inc. in Lansing. The storage cost depends on the number of boxes stored (26 cents per "banker's box" per month). Safe Records, which is temperature controlled, does a significant business in medical records archiving and will retrieve and deliver records for a fee.

The medium-tech option is having your medical records imaged and put in microfilm. This is an excellent option if a physician is seeking a cost-effective, long-lasting archiving method, according to Tom Liebold of Graphic Sciences, Inc., in Royal Oak, Michigan.

"Another advantage of microfilming is that you don't need a computer to access it," Liebold says. "You can always take it down to the public library, put it on a machine and view it."

#### The cost of imaging an entire office full of files depends on the number of images and also the condition of the files. "If the files are wellkept, that can bring the cost down," Liebold

says. "It comes down to how many documents

we can process per hour."

The high-tech option is digital imaging of medical records on CD-ROM. Lason, Inc., in Lansing offers both microfilm and digital imaging of medical records. "If a physician is going to have a low rate of retrieval, we generally recommend microfilm," says Michael Viges, account manager at Lason, a national firm. "We recommend digital imaging for customers that do a lot of look-ups." Another service Lason offers is merging a paper record system with a computerized one, assisting physicians in the conversion or maintenance of computerized medical records, Viges said.

There are numerous firms, which can be located on the Internet, that offer digital conversion of medical records. Typically, they require the physician to box and ship medical records to the company to be imaged. (Most attorneys would not advise this, however, Many recommend that physicians not let original medical records out of their possession.) The medical records are then returned to the physician with two sets of CD-ROMs, one for the office and one for the vault. Two companies that offer this service are ProVisual Data Systems (based in Lexington, Kentucky) and Dictation East, Inc. (based in Lake Park, Florida).

#### What is a long-term solution to many medical record issues and inconveniences?

Short answer: Invest in a computerized medical record system.

Long answer: Although physicians are slow to computerize, it's happening. The sheer bulk of paper medical records coupled with the complexities of doing business are pushing physicians in this direction.

#### Order your free copy of MSMS' Medical Records Information

MSMS members may order a free copy of Medical Records Information, a concise 30page booklet that answers many frequently asked questions about medical records. For your free copy (non-members pay \$24.95), contact Kristen Sabec at MSMS at (517) 336-5769 or ksabec@msms.org.

Indeed, MSMS's Medical Records Information booklet informs physicians that "proper use of a computerized patient record system can improve quality of care by improving organization of patient records, legibility, and completeness. These factors in turn help reduce controllable liability exposure related to patient education and medical record documentation."

Recommended criteria for computer systems should include the following:

- ◆ Document patient history, physical and medical decision-making information
- Document and generate clinical progress
- Maintain patient allergy status
- Document current medications and prescrip-
- Document procedures/tests and results
- ◆ Document no-shows/cancellations
- ◆ Have a mechanism to protect the confidentiality of medical records
- ◆ The patient information system component should maintain and generate patient information/educational material

Chief concerns raised about computerized medical records involve confidentiality, integrity of the record, and availability to physicians when they need it. The MSMS recommendations emphasize strict adherence to procedures designed to control access and protect confidentiality. In addition, protecting data integrity means ensuring stored information is correct and not corrupted in any way. Features such as digital signatures and encryption are necessary to this type of protection. Further, computer systems and data must be available to users whenever they need it. Contingency plans for back-up power should be developed in case of power outage.

The author is an Okemos-based freelance writer.



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<sup>1.</sup> IMS, 1998

Decktor D, et al. A comparison of single-dose Pepcid AC vs. Prilosec 10 mg and 20 mg on human gastric acid secretion. American College of Gastroenterology 62nd Annual Scientific Meeting. Abstract. 1997.

<sup>3. 1998</sup> Drug Topics®, Red Book® Update.

# **Healing Hands** and Generous Hearts.

MSMS Recognizes Volunteer Efforts of Physicians

By Nate S. Pilon

n March 30, 1842, Crawford W. Long, MD, of Jefferson, Georgia, changed the course of medicine forever when he administered the first ether anesthesia to a patient before removing a tumor from the man's neck.

The patient would later swear that he felt nothing and did not realize the operation had been completed until he awoke.

#### The Birth of Doctors' Day

This milestone in medical history became the impetus for celebrating Doctors' Day, a day set aside on March 30 to honor the achievements of the many dedicated physicians who serve their profession above and beyond the call of duty and dedicate their careers to the care of patients and the advancement of the science and technology of medicine.

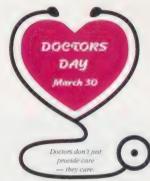
#### Michigan's Superstars

Again this year, MSMS is proud to offer the highest recognition and thanks to our dedicated physicians for all of their "unsung" efforts to better the lives of their patients and to improve their communities. Michigan physicians contribute thousands of hours of volunteer service each year. MSMS is proud to be associated with these caring physicians who donate their valuable time and expertise wherever there is a need.

"Community service projects put a positive and personal face on medicine," said MSMS Alliance President Lila Esfahani, "Volunteer efforts help the public see the face of medicine at work, making a positive difference in people's lives," she concluded.

#### 1998 Efforts Made a Difference

In 1998, Michigan physicians continued to distinguish themselves through their generous contributions in community service and efforts to promote public awareness. "The public re-



sponse to the 1998 Doctors and Their Families Make a Difference Project was phenomenal," commented MSMS President Cathy O. Blight, MD. In carrying out this project, physicians joined forces with families and staff to fill 10,000 collection bags with personal care

items for persons housed in family crisis shelters across the state.

Also, several physician volunteers received special commendations in 1998 for volunteering to serve in a variety of different community projects. These services included free medical care, medical missions, fundraising efforts, volunteer youth coaching, Christmas gifts for needy children, and many other special efforts.

#### Nomingte Your Heroes for 1999

Again this year, MSMS, the MSMS Alliance, the Mutual Insurance Corporation of America, and Stratton, Cheeseman, & Walsh will recognize physicians and their families for their many commitments and special volunteer efforts. MSMS is pleased to be able to show its appreciation and thanks to these caring physicians who continue to make a positive difference in communities throughout the state. Please share with us the names and activities of your colleagues who deserve recognition.

To recognize a colleague, send us their name and a brief description of their volunteer activities. If possible, include a personal or family photo, depicting their activities. Mail your nominees to: MSMS Foundation—Make a Difference, P.O. Box 950, East Lansing, MI 48826-0950; or fax to (517) 337-2490 or email tseelv@msms.org

For further information, contact Judy Marr, executive director, MSMS Foundation, (517) 336-5744 or email jmarr@msms.org.

The author is a communications specialist at MSMS.

Please share with MSMS the names of your colleagues who deserve recognition.

# **Compliance Programs**

Do I Really Need One?



By Charles Cuzydlo, JD

or the past several months, you have been reading and hearing about compliance programs and may have asked yourself "Why do I need a compliance program?"

You should seriously consider implementing a compliance program within your practice for several reasons:

- An appropriate compliance program may help to avoid or mitigate legal action and civil or criminal penalties, which can be triggered by a reimbursement audit
- Compliance programs provide physicians and other providers an opportunity to respond proactively to the present regulatory climate. Various governmental agencies, including the Federal Bureau of Investigation, and private "qui tam" plaintiffs (many of whom are disgruntled health care employees or Medicare/Medicaid patients) have been "deputized" to search for and recover reimbursement for inappropriate and possibly fraudulent claims
- A compliance program not only reflects the integrity of your organization, but helps to identify and prevent billing errors before they occur and to demonstrate that the physician is making a good faith effort to submit claims appropriately

With the above-mentioned factors in mind, the importance of establishing a compliance program within your practice has never been more important.

It is true that there is no federal mandate requiring that you have a compliance program in place. However, it is unquestionably to your benefit to have one.

#### **How Can This Help Your Practice?**

What will the establishment of an effective compliance program do for your practice? First, a compliance program will facilitate better cash flow by ensuring claims are filed correctly the first time, making them less likely to be returned unpaid. Second, even the well-intentioned physician who

tries to follow Medicare guidelines religiously will occasionally make a mistake and if such mistakes follow a pattern, they may attract the attention of fraud investigators.

A physician's participation in an effective compliance plan will stand as evidence that any mistakes were unintentional, and the investigating agency may consider this in determining what action, if any, to take.

By the same token, an ineffective or inactive compliance program may be worse than no program at all. Such a program may be more likely to generate errors than correct them. Not only that, but fraud investigators might well consider the program to be a bad-faith effort to circumvent, rather than enforce, compliance.

#### What Constitutes an Effective **Compliance Program?**

The American Medical Association states that an effective compliance program should include the following elements:

- A general statement of conduct that promotes a clear commitment to compliance
- Appointment of a trustworthy compliance officer with the authority to enforce standards
- Effective training and education programs for all professional and support personnel
- An auditing and monitoring process
- Internal investigation and enforcement through publicized disciplinary guidelines and actions
- A process to respond to identified offenses and apply corrective action initiatives
- Specific and effective lines of communication between the compliance officer and professional and support personnel.

Though these requirements may seem daunting, they are relatively simple to implement. For example, the physician or office manager can serve as the compliance officer so a full-time employee need not be dedicated to that task. Similarly, discussion of compliance-related issues can occur as a segment of regular staff meetings.

Compliance is a collaborative effort between the physician and billing staff. The essential elements of an effective compliance program are direct physician involvement and communication between the physician and billing staff. The billing staff must know which services are to be billed and which amounts to collect.

This information should help physicians

meet their goals to improve the quality of patient care, minimize risk, and reduce the cost of health care. For these reasons, every physician should consider implementing a compliance program.

#### For Further Information

For more information regarding compliance programs, please contact Charles Cuzydlo, JD, MSMS chief of Legal and Regulatory Affairs, at (517) 336-5714 or ccuzydlo@msms.org or check out our Website at http://www.msms.org.



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# Physicians' Hobbies Enrich Lives

Art and Nature are Their Other Callings

By Ralph D. Ward



Pyatt Lake Nature Preserve-Old Mission Penninsula

#### Preserving a Piece of Nature

Suppose you have some land set aside as a nature preserve, and someone discovers oil on that land. What do you do? Well, if you're the Grand Traverse Regional Land Conservancy, you put the money to good use preserving a whole lot more nature.

Ken Musson, MD, Traverse City ophthalmologist and MSMS Board member, has long been active in the West Michigan conservation movement, and was in on the beginning of the area's highly successful land preservation system. Doctor Musson is a member of the Traverse City Rotary Club, one of the most diversified Rotary units in the state, and one of the most noted for supporting charitable causes.

Doctor Musson recalls that the group had been willed a section of local land about 60 years ago for a Boy Scout camp. The land quietly served its scouting role for decades—until an interesting discovery was made. "In the early '70s we found that the camp was part of a major oil find. We now have six oil wells on the land." Income from the wells has not only been used to keep most of the site in its natural state, but to acquire further conservation land and support local charities. In 1991, the Grand Traverse Regional Land Conservancy was formed to manage the acquired lands, and has since become an independent entity, protecting over 3,400 acres of land, including 15 miles of Lake Michigan shoreline.

While the Rotary charities have grown to become a major fund, with an endowment of almost \$30 million, Doctor Musson prefers to measure the achievements seen in his Traverse Bay backyard. "It's been tremendous; we've been able to preserve lakeshore, wetlands, and



Ken Musson, MD



Fall colors reflect on a calm Pyatt Lake, preserved through Rotarians' efforts.

wilderness that would have been developed. Now miles of lakeshore are protected in perpetuity."

# Artistic Contribution Enhances Hospital, Soothes Patients

Medicine *can* be a work of art — just ask William Johnston, MD. Doctor Johnston, a Grand Rapids-based general surgeon, was affiliated closely with Butterworth Hospital until his retirement in 1983. He had achieved the position of surgical department chair at the hospital by that time, but it's his hobby in art collecting that allows him to make a truly unique contribution to the hospital.

"I've always found that most hospital corridors are white, tall, and stark," Doctor Johnston recalls. "But the people who come into a hospital spend a lot of time wandering those corridors. I thought that if they had something enjoyable to look at, it would soothe some of their anxiety." In 1967, Doctor Johnston set out to launch a Butterworth art collection. After initially donating 10 pieces he and wife Beverly had collected, he asked everyone on the medical staff to give him a check for \$25 to acquire some paintings. But after three months he had

all of \$25—and he was the one who'd donated it.

Undaunted. Doctor Johnston tried another tactic, seeking out worthwhile paintings for sale, and approaching Butterworth patrons to donate the money for acquisition. This method proved successful, and after a few years, the medical staff finally pitched in to create an art fund, now managed bv the Butterworth-Blodgett Foundation.

Since his retirement, Doctor Johnston has dedicated much of his time to building the Butterworth art collection. "We have a number of pieces by noted Michigan artists, including Matthias Alton and Roy Gamble." Doctor Johnston keeps his eyes open for pieces that can brighten the mood of hospital visitors, and the hospital has learned to trust his judgment. "In 1988 we were offered a painting by a noted artist, but the subject was a bloody, dead French soldier. I said that putting a painting like that in a hospital would cause a lot of problems." Doctor Johnston was overruled, however, and the piece was purchased and displayed. "In the first month we received 48 letters objecting to the painting." Today, you won't find any dead soldiers decorating the halls at Butterworth Hospital.

# Preserving the Walk on the Wild Side

Physicians can take their careers wherever they choose to live, but John Hall, MD, has gone the extra step of working to keep that place the way he found it. Doctor Hall, a Petoskyarea urologist has practiced most of his career in the Little Traverse region that he loves. "I



John Hall, MD



Colonial Point Forest

choose to work here rather than Lansing or Detroit because I value the ability to go for a walk in the woods. This is my personal value statement."

But as rural development pushed north into the Little Traverse region, Doctor Hall and others in the area saw their lifestyle under threat. "We've seen some pristine land under development here—controlled development is good, but uncontrolled development isn't." In the mid-1970s, Doctor Hall joined with other concerned locals in forming the Little Traverse Conservancy to acquire and shelter wild areas. In the past 25 years, the conservancy has acquired over 7,000 acres and accepted conservation easements for 2,000 more. The areas now protected include forest, fragile dunes, wetlands, and some of the Great Lakes most beautiful shoreline areas. The Little Traverse conservancy also offers environmental Little Sand Bay Nature Preserve

education programs to 6,000 local school children yearly.

The conservancy system allows small, separated plots of land to be acquired and consolidated, rather than the large acreage usually required by state programs. "We have areas with 400 yearold hardwoods, unique animal species and vegetation." Hall credits the conservancy concept with nurturing a longterm view of the area's resources. "Along M-119, for example, there is some uniquely beautiful acreage. Without conservation, though, growth would turn it into one long strip mall." Despite the conservancy's successes, however, the group continues to seek natural land for preservation. "The press for development will never rest."

The author is a Riverdale-based freelance writer.



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# MSMS' Answer People

MSRs Keep Physicians Informed

#### By Colin Ford

ember Service Representatives (MSRs) were established at MSMS for a simple purpose—to help its members and to provide them the help they need.

Because doctors and their staffs are busier than ever before, MSMS assists physicians in a more convenient environment—in their offices, MSRs stand ready to visit your office at no charge.

In a continuing effort to bring physicians the most up-to-date, useful information, this column will appear frequently in Michigan Medicine, and will highlight questions from MSMS physicians, answers, and pertinent information to enhance your practice.

#### Does MSMS review how effectively a practice is operating in a managed care environment?

An MSMS/MICOA subisidiary, Medical Advantage Group (MAG) offers a Managed Care Readiness Assessment program. MAG has developed a managed care readiness tool to help physicians understand the nature of the changing health care marketplace and to measure their readiness to successfully provide services in a managed care environment. In determining the readiness of an individual physician or a physician group to successfully engage in managed care contracting, MAG examines many areas including organizational structure, financial stability, provider referral network, contracts/compensation, and utilization management. MAG then develops a report that discusses how the practice compares to each key characteristic.

The report also includes recommendations for improvement. To learn more about the MAG Managed Care Readiness Assessment, call Tom Wolff, ID, MAG's Manager of Physician Networks and Contracting Services, at (517) 324-6989.



#### Is there a minimum amount required to join MDPAC?

To become a Sustaining Member of the Michigan Doctors' Political Action Committee, physicians or their spouses are

asked to contribute \$150. A family membership, which is \$225, gives membership to both the physician and their spouse. The money raised by MDPAC is used to fund extensive grassroots efforts that ensure that physicians have access to lawmakers, and the rights of the physicianpatient relationship are protected in the legislative process. Physician contributions have helped MDPAC gain recognition as one of the most successful statewide PACs in Michigan. The success also is due to the widespread physician and Alliance participation in candidate interviews, endorsements, volunteer support, and candidate fundraisers.

To receive further information, or to join MDPAC, contact Matthew C. Hedberg at (517) 336-5719 or at mhedberg@msms.org. ■

The author is an MSR for MSMS.

#### For Further Information

To schedule an appointment with your MSR or inquire about MSMS services, please contact the Member Service Representative Department at (517) 336-5749.

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For assistance in establishing your legacy through the MSMS Foundation, please contact:

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# Controversies in End-of-Life Care

Thursday, May 18, 1999 8:30 a.m. to 4:30 p.m.

Amway Grand Plaza Hotel - Grand Rapids

This third conference on end-of-life care will look some of the controversial issues surrounding the care of patients as they near the end of life. State and nationally recognized experts will discuss topics such as malpractice risks that may arise when treating a dying patient, how to deal with a request for futile care and a Proposal B Retrospective – Now What?

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#### NEWSMAKERS



Thomas M. George, MD, a Kalamazoo anesthesiologist, recently was elected vice president of the Michigan Historical Society. Doctor George's interest and involvement in history goes far beyond a hobby. He has produced several awardwinning video documentaries, including "Lincoln in Kalamazoo," and "Kalamazoo in World War I."

Robert C. Ward, DO, a St. Joseph neurologist, is the recipient of the 1998 Annual Taylor Still Medallion of Honor Award from the American Academy of Osteopathy (AAO). Each year, the AAO presents this award to members who have demonstrated an exceptional understanding and application of osteopathic principles.

Bernhardt L. Pederson, MD, recently received a BS in civil engineering from the University of Michigan. Doctor Pederson is a retired obstetrician and gynecologist from Bay City.

George Smith, MD, was a recipient of the Terri Wright Outstanding Achievement Award by the Michigan Healthy Mothers/Healthy Babies Coalition, Doctor Smith was chosen for this award because of his promotion of access to prenatal care in the Greater Lansing area, and for his work at the Jean Granger Prenatal Clinic. He has worked at the Jean Granger clinic for nearly 28 years. where he ensured that over 3,000 women have received free or lowcost prenatal care, and also delivered over 2,500 babies.

Deborah Ochs, MD, recently was appointed to the board of Munson Medical Center and Hospitals. Doctor Ochs, of Traverse City, specializes in pulmonary and internal medicine with special qualifications in critical care medicine and pulmonary disease.



Ronald B. Irwin, MD, recently was named director of Oncologic Services at William Beaumont Hospital. Doctor Irwin, a Beverly Hills orthopaedic surgeon, specializes in musculoskeletal oncology. He also is director of the Musculoskeletal Tumor Service at Beaumont and serves on the hospital's Board of Trustees.

#### **NEW MEMBERS**

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Anan Abdelrahman, MD Bloomfield Carmela A. Abessinio, DO Grosse Pointe Woods A.S.M. Akter Ahmed, MD Detroit Raphael A. Buckle, MD Hillsdale Michael E. Cannon, MD Southfield Conway Chin, DO Bay City Elena G. Chiorean, MD Hancock Hicham Churbaji, MD Flint Edward Coniewski, MD Ybsilanti Paul J. Corsi, MD Bloomfield Hills David Criss, MD West Bloomfield Dennis C. Dafnis, MD Coldwater Duane J. DiFranco, MD Dearborn Terry L. Donat, MD Novi Doss N. Doss, MD Dearborn David Gurevitch, MD Farmington Hills

Allison Heimer, MD Kalamazoo Nancy A. Herringshaw, MD Sterling Heights Stacy Gambrell Hunt, MD Flint Thurman Hunt, MD Flint Camille E. Kempke, MD Hancock Alfred K. Newton, MD Detroit Eric Orenstein, MD Greenville

Jeffrey L. Harris, DO Lapeer

Stephen H. Orr, MD Kalamazoo John Pawlovich, MD Troy Laxmi N. Prasad, MD Farmington Hills Jasbir S. Rangi, MD Troy Annemarie Romanik-Patenaude, MD Novi Kevin Shea, MD Birmingham Chander K. Sikand, MD Bloomfield Hills Niroo B. Talwar, MD Grand Blanc Kurt A. Westley, MD Livonia Robert J. Wolf, MD Davison

#### **OBITUARIES**

Donald J. Birmingham, MD, died on June 15, 1998. He was 86. Doctor Birmingham graduated from St. Louis University School of Medicine in 1940 and later established a dermatology practice in Grosse Pte. Woods. He was a member of the Michigan Dermatological Society, Wayne County Medical Society, AMA, and MSMS.

Faith B. Fritsch, DO, a Dewitt general practitioner, died on November 5, 1998. She was 65. Doctor Fritsch graduated from Chicago College of Osteopathic Medicine in 1971. She was a member of the Michigan Association of Osteopathic General Practitioners, the National Osteopathic Board of Examiners, Ingham County Medical Society, and MSMS.

Lore Hirsch, MD, died on October 15, 1998. She was 90. Doctor Hirsch graduated from Heidelberg University Medical School in West

Germany in 1939 and later practiced psychiatry in Dearborn. She was a member of Michigan Psychiatric Society, American Psychiatric Association, Wayne County Medical Society, AMA, and MSMS.

William J. Jones, MD, died on August 26, 1998. He was 84. Doctor Jones graduated from Syracuse University Medical School in 1947. During WWII he served in the army from 1944-46. Doctor Jones, a pediatrician from Wayne county, was a member of Academy of Pediatrics, Detroit Pediatric Society, Past-President of Civilian Aviation Medical Association, a member of Wayne County Medical Society, AMA, and MSMS.

Nelson Singer, MD, died on October 18, 1998. He was 88. Doctor Singer graduated from Wayne State University School of Medicine in 1938 and later set up general practice in Eastpointe. He was a member of Macomb County Medical Society and MSMS.

Robert C. Davis, MD, a Flint family practitioner, died in December 1998. He was 81. Doctor Davis graduated from the University of Michigan Medical School in 1951. He served in the army during WWII from 1942-47. Doctor Davis was a member of Michigan Academy of Family Practice, American Academy of Family Practice, Genesee County Medical Society, AMA, and MSMS.

John L. Riker, MD, died in November 1998. He was 79. Doctor

Riker graduated from the University of Michigan Medical School in 1943 and later established an ophthalmology practice in Ossineke. He served in the navy during WWII in 1946. Doctor Riker was a member of American Academy of Ophthalmology, Alpena-Alcona-Presque Isle County Medical Society, AMA, and MSMS.

Anton Zadurowycz, MD, a Warren family practitioner, died in December 1998. He was 78. Doctor Zadurowycz graduated from the University Medical School in Innsbruck, Austria in 1955. He was a member of Michigan Academy of Family Practice, Wayne County Medical Society, AMA, and MSMS.



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#### DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Consumer and Industry Services, Office of Health Services.

Name: Andrejs Dimants, MD, P.O. Box 189, Three Rivers, MI 49093

Action, Date Taken: 12-01-98, Reinstatement Denied

Name: Leslie D. McBeath, MD, 9773 Abi Court, Plymouth, MI 48170

Action, Date Taken: 12-01-98, Reinstatement Denied

Name: Michael W. Mott, MD, 2647 Pine Dunes Dr., SW, Grandville, MI 49418

Action, Date Taken: 12-03-98, Reprimand, Fine-\$1,000.00, Probation- 2 yrs.

Reason: Failure to Meet Continuing Education Requirements

Name: John H. Romanik, MD, 20000 Beck Rd., Northville, MI 48167

Action, Date Taken: 12-13-98, Fine-\$10.00

Reason: Failure to Meet Continuing Education Requirements

Name: Marvin Shulman, MD, 16530 19 Mile Rd.,

Clinton Township, MI, 48038

Action, Date Taken: 11-24-98, Reprimand, Fine-\$1,000.00, Probation— 2 yrs.

Reason: Failure to Meet Continuing Education Requirements

Name: Thomas G. Hicks, MD, 777 Indian Hills Dr., Hastings, MI 49058

Action, Date Taken: 11-18-98, Remanded from the Barry County Circuit Court, Probation—1 yr.

Reason: Drug Related

Name: Mark K. Levine, MD, 818 Riverside Ave., Adrian, MI 49221

Action, Date Taken: 12-18-98, Reprimand Reason: Sister State Disciplinary Action

Name: Roger D. Miller, MD, 1300 Michigan, NE, Ste.

201, Grand Rapids, MI 49503

Action, Date Taken: 11-18-98, Reprimand, Fine-\$1,000.00

Reason: Negligence/Incompetence

Name: Joseph I. Nosanchuk, MD, 31915 W. 14 Mile Rd. #243, Farmington Hills, MI 48334

Action, Date Taken: 12-18-98, Reprimand, Probation—

Reason: Failure to Meet Continuing Education Requirements

Name: Michael Weisenfeld, MD, 20501 Glastonburg, Detroit, MI 48219

Action, Date Taken: 11-18-98, License Suspended–18

mo., Summary Suspension Dissolved Reason: Criminal Conviction



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#### **MSMS Meetings** April

- 6, MSMS Medical Business Specialist Program—"Introduction of CPT-4 Coding-The Basics!" Location: Troy Marriott, Troy, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 7, MSMS Committee on Aging. Location: MSMS Headquarters, East Lansing, MI, 3:00 p.m.-5:00 p.m. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 7, MSMS Committee on State Legislation and Regulations. Location: MSMS Headquarters, East Lansing, MI, 2:00-5:00 p.m. Contact: Greg Aronin at MSMS at (517) 336-5739 or garonin@msms.org.
- 7, The Michigan Department of Community Health conference "Working toward a Lead-Safe Michigan." Location: Bronson Methodist Hospital, Kalamazoo, MI. Contact: Childhood Lead Poisoning Prevention Project at (517) 335-8885.
- 8, MSMS Medical Business Specialist Program-"Introduction of CPT-4 Coding-The Basics!" Location: WMU-Fetzer Center, Kalamazoo, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.
- 9, MSMS HMO Medical Directors. Location: MSMS Headquarters, East Lansing, MI, 12:00-2:00

- p.m. Contact: Julie Lester at MSMS 336-5768 (517)ilester@msms.org.
- 13, MSMS Medical Business Specialist Program—"Introduction of ICD-9-CM Coding-The Basics!" Location: Hampton Inn, Warren, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at 336-7581 (517)jmogyoros@msms.org.
- 15, MSMS Medical Business Specialist Program—"Introduction of ICD-9-CM Coding-The Basics!" Location: WMU-Fetzer Center. Kalamazoo, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.
- 15, MSMS Center for Physician Education and Leadership presents "Corporate Compliance: Fraud and Abuse." Location: Munson Medical Center, Traverse City, MI, 6:00-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 13, MSMS Medical Business Specialist Program—"How to Improve Your Office and Reception Skills" Location: MSMS Headquarters, East Lansing, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 21, MSMS Center for Physician **Education and Leadership presents** "Corporate Compliance: Fraud and Abuse." Location: Hampton

- Inn, Warren, MI, 6:00 p.m.-9:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 27, MSMS Medical Business Spe-Program-"Medical Records & the Law" Location: St. Mary's Health Education Center, Saginaw, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or imogyoros@msms.org.
- 27, MSMS/MICOA Closed Claim Review. Location: Alpena, MI. Contact: Kristen Sabec at MSMS at (517) 336-7587 or ksabec@msms.org.
- 28, MSMS/MICOA Closed Claim Review. Location: Gaylord, MI. Contact: Kristen Sabec at MSMS at 336-7587 (517)ksabec@msms.org.
- 28, MSMS Center for Physician Education and Leadership presents "Negotiations Seminar" Location: Amway Grand, Grand Rapids, MI, 8:00 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 29, MSMS Medical Business Specialist Program—"Medical Records & the Law" Location: Hampton Inn, Warren, MI, 8:30 a.m.-4:00 p.m. Contact: Jennifer Mogyoros at MSMS at (517) 336-7581 or jmogyoros@msms.org.
- 30, MSMS Board of Directors Meeting. Location: Ritz Carlton

Hotel, Dearborn, MI, 3:00 p.m. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.

30-5/02, MSMS House of Delegates Meeting. Location: Ritz Carlton Hotel, Dearborn, MI. Contact: Irene Frost at MSMS at (517) 336-5743 or ifrost@msms.org.

#### MAY

- 2, MSMS Board of Directors Meeting. Location: Ritz Carlton Hotel, Dearborn, MI. Contact: Irene Frost (517)336-5734 or ifrost@msms.org.
- 2-4, MSMS Alliance Annual Meeting - House of Delegates. Location: Flint, MI. Contact: Liz Foster (517)336-7587 or lfoster@msms.org.
- 4, MSMS Medical Business Specialist Program - "CPT-4 Coding: The Next Step." Location: Hampton Inn, Warren, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 6, MSMS Medical Business Specialist Program - "CPT-4 Coding: The Next Step." Location: WMU - Regional Education Center, Grand Rapids, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 6, Corporate Compliance: Fraud and Abuse Seminar. Location: Harbor Holiday Inn, Muskegon, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or imogyoros@msms.org.

#### SPECIALTY SOCIETIES APRIL

- 2, Michigan Society of Respiratory Care Board Meeting. Location: MSMS Headquarters, East Lansing, MI 9:00 a.m.-4:00 p.m. Contact: Liz Foster at MSMS at (517) 336-7587 or lfoster@msms.org.
- 10, Michigan Association of Physician Assistants. Location: Traverse City, MI. Contact: Tom O'Keefe at MSMS at (517) 336-7589 or tokeefe@msms.org.
- 15, Michigan Ophthalmological Society. Location: Westin Hotel, Southfield, MI. Contact: Tom O'Keefe at MSMS at (517) 336-7589 or tokeefe@msms.org.
- 21, Michigan Dermatological Society Meeting. Location: Sacred Heart, Detroit, MI. Contact: Carrie Brock at MSMS at (517) 336-7586 or cbrock@msms.org.
- 22-23, Michigan Medical Group Management Association Spring Meeting. Location: Troy Marriott Hotel, Troy, MI. Contact: Melissa Wiegand at MSMS at (517) 336-7599 or mwiegand@msms.org.
- 23-24, Michigan Society of Anesthesiologists Annual Meeting. Location: Ritz-Carlton, Dearborn, MI. Contact: Tom O'Keefe at MSMS at 336-7589 tokeefe@msms.org.
- 27-30, Michigan Society of Respiratory Care Spring Meeting. Location: Troy Marriott Hotel, Troy, MI.

Contact: Liz Foster at MSMS at 336-7587 (517)lfoster@msms.org.

#### MAY

- 1, Michigan Society of Pathologists Meeting. Location: Greenfield Village, Dearborn, MI. Contact: Carrie Brock at (517) 336-7586 or cbrock@msms.org.
- 5-8, Michigan Chapter, American College of Surgeons. Location: Boyne Highlands. Contact: Carrie Brock at (517) 336-7586 or cbrock@msms.org.
- 12, Michigan Allergy & Asthma Society. Location: University of Michigan, Ann Arbor, MI. Contact: Melissa Wiegand at (517) 336-7599 or mwiegand@msms.org.
- 19, Michigan Society of Respiratory Care Pulmonary Rehab Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or lfoster@msms.org.

#### **AMA MEETINGS** JUNE

22-24, AMA Annual Meeting. Location: Chicago Hilton, Chicago, IL. Contact: Judy Marr at (517) 336-5727 or jmarr@msms.org.



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#### Do Unto Others

By Cathy O. Blight, MD MSMS President



I often wonder as I am browsing through the stacks at the local bookstore, what an alien might think of us as a culture if she were to land in our midst. The self-help books like Wine for Dummies abound. "Miss Manners" instructs us how to behave properly and answers our questions about suitable actions in social situations, while the "Fashion Doctor" makes sure we are appropriately attired. All of the things our mothers talked to us about seem to have fallen on deaf ears, or our memory capacity has severely diminished.

Even in our professional lives, tasks that were once taken for granted now need a blueprint for execution. In this issue of Michigan Medicine, we get new insight into the time-honored tradition of closing or selling a medical practice (now called "practice disposition"). In our grandparents' days, the kindly local physician simply looked for a new doctor to come in and "take over." There was little concern about continuity of patient records, the value of capital assets or intangibles like "good will." Now, all these things must be accounted for before we start other life activities.

So, with the "rules of life" changing at every turn, is there nothing we can feel comfortable with? I think there is, and it harkens back to the Bible's admonition, "do unto others as you would have them do unto vou."

I am constantly amazed when some physicians complain about the loss of "professional courtesy." The

rules certainly have changed in this area. There was a time when physicians would treat other physicians and their families for free. Now, it is seen as an inducement for referrals and major penalties and fines can result if a physician in "caught." Doctors complain, rightly so, that they should be able to give their services away for free to whomever they want. But, "big brother government" has changed the rules.

> 66 In this day and age, when we feel at a loss to control our environment. shouldn't we strive to control what we can? We can make everyone's life a little better by being more attuned to our words and actions. 99

With this change, we should ask ourselves do we treat our colleagues courteously? In an article last fall in Medical Economics, David Karp, loss prevention manager for the Medical Insurance Exchange of California, noted that about one quarter of the malpractice suits one

liability carrier studied could be traced to critical remarks made by one doctor about another. In none of the cases had the criticizing physician reviewed the case or discussed it with the treating physician. He states, "Inter-professional sniping, or 'jousting' as it is often called, still flourishes. Injudicious, uninformed criticism is another valuable gift the medical profession donates to lawvers."

Sometimes, I am privy to at least one end of a telephone conversation between a physician and my office staff. In some instances, from the reaction at my end, the person at the other end is not as courteous as they could be. And, it often spills over into how office staffs interact. Maybe because they see and hear the physician deal rudely with staff in other offices, they feel they can do the same. Often, we allow stress, frustration, and impatience intercede in our conversations, when a deep breath and a modicum of patience would help us all.

In this day and age, when we feel at a loss to control our environment. shouldn't we strive to control what we can? We can make everyone's life a little better by being more attuned to our words and actions. If we need the "do unto others" philosophy, the whole concept of "professional courtesy" could take on a new meaning. "Personal courtesy" and civility to the profession could enhance our image as a patient/person focussed profession, and shape the environment that we are given.

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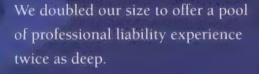
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# Michigan Medicine

#### COVER STORY



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# The Truth about Mergers and Acquisitions: Recommendations for Physicians in a Dynamically Changing

Health Care Environment

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Mergers and acquisition issues have been a business flashpoint for two decades as noted business names have disappeared, millions of jobs have been cut, and fortunes have been made—or lost—by savvy merger and acquisition dealings. While physician practice mergers and acquisitions lack the headline potential of Daimler merging with Chrysler, the pitfalls above still may apply.

By Ralph D. Ward

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## **Surfing Medical Internet Sites**

By Randy Gavorin

pproximately 513,819,500 Websites exist today. The Internet certainly can be an overwhelming resource for anyone attempting to locate medical related homepages.

Still, many medical Webpages on the Internet are tremendously helpful for physicians and patients. Medical Websites today are becoming interactive, enhancing the availability of information. The following medical sites are a sampling of useful Internet homepages for physicians to explore and MSMS provides handy links to them.

■ MSMSNET, http://www.msms.org, offers a variety of information for Michigan physicians. Medigram and Michigan Medicine are provided online before the print copies are distributed, allowing users to gain a head start on each publication's content. MSMS also has information on educational opportunities, medical economics, e-commerce, and political action. These resources attach over 8,500 people to this page each month.

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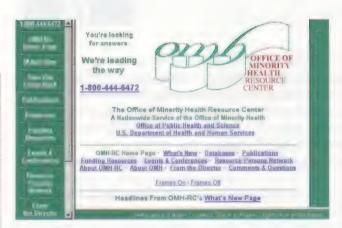
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cal research news. This site also has the capability of searching 77 different medical topics ranging from acid reflux to women's health. Mediconsult.com offers journal articles. This is an opportunity to access the latest advancements from medical journals for physicians and specialists. This Webpage also created a medical online community through support groups, such as a cancer discussion group, monitored by medical professionals and experts. Educational material and drug

information are resources also available on this homepage.



The Virtual Hospital, http:// indy.radiology.uiowa.edu/, is a digital health sciences library created at the University of Iowa to help meet the information needs of health care providers and patients. The goal of the Virtual Hospital is to make the Internet a useful medical reference and health promotion tool. The Virtual Hospital contains hundreds of books and brochures, which are searchable through specialties, departments, or by literature type. This online hospital makes its material available for both health care providers and patients.



■ The Office of Minority Health Resource Center (OMH-RC), http://www.omhrc.gov/, was established by the U.S. Department of Health and Human Services Office of Minority Health. OMH-RC serves as a national resource and referral service on minority health issues. It advises the Office of Public Health and Science on public health program activities affecting American Indian and Alaskan Natives, African American, Asian American, Pacific Islander, and Hispanic populations. Its goal is to promote improved health among these racial and ethnic minority populations.

■ Another interesting site to explore is the Program for Monitoring Emerging Diseases (ProMED), http://www.mwsearch.com/. Its goal is to educate populations in hopes of preventing another pandemic such as AIDS. ProMED functions as an international collaboration of leading human, animal, and plant disease professionals, working to identify scientific and medical assets. As an electronic information resource, ProMED-mail links scientists, public health officials, journalists, and laypersons in a prototypical global communications network for reporting disease outbreaks.

**Search Engines** 

Which search engine produces the best results for your query? Five common search engines are available to help find resources available on the Internet. Finding the appropriate medical resources, however, can be very

challenging. To aid you in your search, see Medical World Search at http:// www.fas.org/promed/index.html. This will enable you to scan nearly 100,000 full-text Webpages from thousands of selected medical sites.

If you need additional information regarding MSMSNet or other related Websites, please contact Randy Gavorin at MSMS at (517) 336-7594 or

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The author is Internet Systems Coordinator at MSMS.



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#### Spousal Liability for Medical Fees

By Richard D. Weber, JD

MSMS Legal Counsel



Question: I have several accounts due that I am turning over to small-claims court for the purpose of collection. I plan to name as defendants both the patient and his/her spouse. I have heard that there is a new law that will not allow me to proceed with collection from the spouse unless I have informed the spouse in advance. Is this true? If so, how should I go about informing my patients and their spouses, and may I have sample language I might use in a notice?

Answer: In May, 1998, the Supreme Court changed the existing law in this area. In that landmark decision, the Supreme Court held that neither a husband nor a wife is liable, absent an express agreement, for necessaries supplied to the other spouse. Necessaries clearly include medical services. Prior to the Supreme Court's ruling, a spouse was legally liable for the payment of medical services provided to the other spouse. A brief explanation is in order.

At common law, the "necessaries doctrine" essentially made husbands liable for all necessaries provided to their wives. The primary purpose was to assure that dependent wives received support from neglectful husbands. On the other hand, the common law doctrine did not recognize a reciprocal liability on the part of the wife for the husband's necessaries. Michigan later enacted the Married Women's Property Act (MWPA), which specifically declared that a wife's separate property is not subject to her husband's debts.

In 1983, the Michigan Court of Appeals held MWPA unconstitutional as violative of the equal protection of the law clauses of the State and Federal Constitutions. The Court of Appeals, in eliminating the distinction between a wife and a husband in the context of liability for the other's debts, held that both spouses are liable for the medical expenses of the other spouse. The constitution requires a gender neutral scheme. The Court of Appeals in the case before the Supreme Court last year followed the 1983 case and held that MWPA was unconstitutional and, therefore, a wife was held to be liable for the medical necessities of her husband. The Supreme Court reversed and held that MWPA was indeed constitutional and that it bars a judgment against a wife for her husband's medical expenses. Applying the gender neutral constitutional standard, the Court then abrogated the common law doctrine and held that neither a husband nor a wife is liable for the necessaries supplied to the other, absent an express agreement. The Court determined that, when applied to married men only, the necessaries doctrine qualifies as genderbased discrimination and offends the principle of equal protection of the law. Therefore, if a wife is protected against claims for medical fees incurred with respect to a husband, a husband must be protected in the same fashion against claims for medical fees incurred with respect to a wife.

Your question implies that mere notification to a non-patient spouse will cause that spouse to be liable for the medical expenses of the patient spouse. This is erroneous. An express agreement by a non-patient spouse is required for that spouse to be liable for the debts of the patient spouse. Such an agreement can be simple, but it should be clear and in writing. Sophisticated medical offices have payment policies which, among other things, require the patient to pay for all charges within a specified time period, to the extent there is either no insurance or the charge is not fully covered by insurance. That document, which is typically signed by the patient, should also be signed by the patient's spouse. For example, the patient's spouse could guarantee payment by adding the following language:

The undersigned, being the spouse of the patient named above, hereby guarantees full and prompt payment of all fees and expenses incurred by or on behalf of my spouse as a medical patient.

Signature:

Date:

There is a fundamental legal issue as to whether the applicable

**Editor's note:** If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Kristen Lare, managing editor, P.O. Box 950, East Lansing, MI 48826-0950.

Michigan law prior to the Supreme Court decision in May, 1998 would apply to debts incurred prior to that decision. Although constitutional decisions are typically applied retroactively, there is some authority that would support the change only on a prospective basis. Legal research and analysis necessary to opine on this issue is beyond the scope of this column.

The author is senior partner with Kerr, Russell, & Weber, Detroit.

The author is senior partner with Kerr, Russell, and Weber, Detroit.



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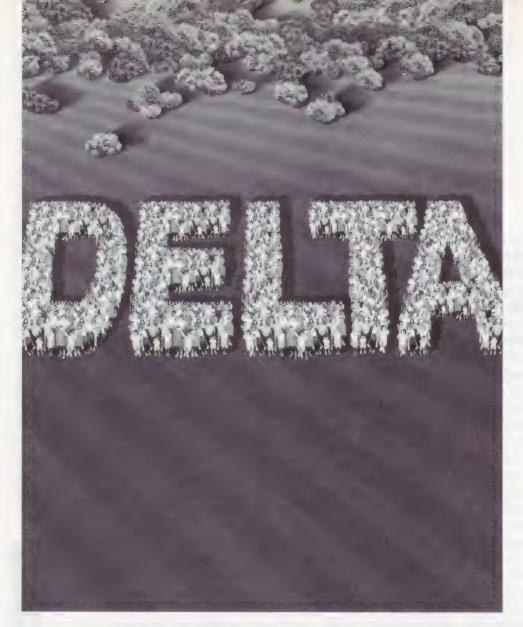
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#### TENTATIVE AGENDA

#### 8:00 a.m. - 8:30 a.m. Registration • Program Introduction - Krishna K. Sawhney, MD, President • Justice of the Supreme Court, The Honorable Maura Corrigan MSMSA Update Senate Majority Leader, Dan DeGrow Attorney General Jennifer Granholm • Capitol Press Core Presentation • Tim Skubick - NBC, Lansing • Rob Baykian, Executive Director - Michigan Radio Network • Larry Lee, President - Gongwer Capitol News Service • House Minority Leader, Mike Hanley Wrap up – Krishna K. Sawhney, MD, President 11:45 a.m. - 1:15 p.m. Lunch on the lawn of the Capitol 1:30 p.m. - 3:00 p.m. Special Breakout Sessions Meetings with Legislative Leadership Special Issue Session Tour of the Capitol

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## Physicians' Bridge over **Troubled Waters**

By Ahmad Abdul-Qadir

"They [MAG] offer a much more comprehensive range of services, but they still are physician friendly and more effective than ever." -AppaRao Mukkamala, MD, MSMS and MAG

**Board Member** 

he tide has shifted in favor of physicians and the health care industry at large. Until recently, Michigan's physician groups had to rely on several different organizations to meet their needs for services ranging from peer review to managed care contracting analysis. Medical Advantage Group (MAG) has come forth as the new leader in health care related services.

The product of Michigan Medical Advantage (MMA) and the Winchester Group, two companies that already had established good reputations among Michigan physicians and hospitals, respectively, MAG is bolder and better than ever.

"This is the most comprehensive organization of its type. Physician groups may receive a portion of our services from other companies, but they simply cannot receive the vast range of services that MAG offers anywhere else in Michigan," says Krishna K. Sawhney, MAG chair and MSMS president-elect. MAG is owned by a group of physician-investors, MSMS, and the Mutual Insurance Corporation of America (MICOA).

#### Management

Under the leadership of two health care industry veterans, Larry Schwartz and Kevin Cawley, MAG is poised for a promising future. This translates into good news for Michigan physicians. With more than 25 years of experience, MAG President and Chief Executive Officer Larry Schwartz has worked in the health care industry since the early days of managed care. He started the Winchester Group in 1988 to strategically position HMOs and PPOs in the managed care industry.

Having witnessed the transition from Common Provider Entities (CPE) to today's PHOs, Schwartz has functioned in the midst of a system that is constantly evolving. "Plans and providers have learned a great deal. The market place was not heavily penetrated 10 years ago, but there was a great deal of activity," says Schwartz. That early industry activity taught Schwartz the significance of "raising the bar," pushing quality to the highest possible levels in order to maintain strong client relationships.

MAG Chief Operating Officer, Kevin Cawley, has invested 16 years in the health care industry. In that span he has acquired extensive knowledge and experience with all financial issues related to health care. He has developed integrated delivery networks, MCOs, and hospital and physician practices. Prior to the formation of MAG, Cawley was the COO of Michigan Medical Advantage.

#### **Purpose**

MAG's primary goal is to "develop a model to efficiently transform managed care into an integrated unit," says Cawley. He feels that hospitals, physicians, and third-party payers need to "keep incentives aligned to ensure success." This is really the heart of what MAG brings to physicians: an equal voice at the bargaining table. Without an advocate like MAG, it is increasingly difficult to negotiate contract terms

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Larry Schwartz

in today's managed care environment. These days, the importance building the right relationships cannot be overemphasized. The staff at MAG understands



Kevin Cawley

this fact, and they bring a solid infrastructure to physician groups, which, in turn, allows physicians to focus more on practicing medicine, and less on time-consuming business affairs.

MAG deals directly with IPAs, PHOs, hospitals, and health plans. They are best equipped to work with groups comprising between 20 and 300 physicians, caring for between 4,000 and 40,000 patients, and affiliated with at least one hospital and third-party payer.

#### **Process**

Routinely, MAG begins with a new client by designing a control model on governance of the contracting entity. Once it has been decided how things will be operated, MAG helps clients to negotiate a successful payer arrangement with attractive incentives for all parties involved.

An important issue to bear in mind is, while MAG places physicians on an equal level with hospitals and third-party payers at the bargaining table, in the past, some individuals mistakenly viewed MAG (then MMA) as antiinstitutional. They felt that because the group was physician-owned and physician-minded, the group's main purpose was to arm physicians

to do battle with hospitals and insurers in a hostile managed care environment.

"We are not anti-institutional, although many have misinterpreted us as being that way. We certainly are physician friendly, and that is not going change, but we want our clients to know that we also are sensitive to the concerns of hospitals and third party payers as well," says Schwartz.

By valuing integration over separation in health care, MAG presents a broad skill set to clients that would not have been available otherwise. MAG clients take advantage of collaborative relationships, not adversarial opposition. This major benefit may help to explain why over 1,400 physicians sought MAG (then MMA) services in 1997 alone. MAG's new composition is able to serve physicians as never before.

The Advantage

"The real synergy of MAG's current structure is combining Winchester's advanced standing and hospital organizations with MMA's strong physician relationships," Cawley remarked. "MAG has diversified it's activities to include services ranging from credentialing to practice management and managed care contracting," said AppaRao Mukkamala, MD, MAG Board Member. "They offer a much more comprehensive range of services, but they still are physician friendly and more effective than ever."

Another part of setting up new client relationships is implementing control mechanisms to help clients reach their financial goals. "You cannot manage what you cannot measure," says Cawley, referring to the necessity for quantitative controls. MAG profiles physician utilization with Peer-A-Med®, a high-tech physician profiling software solution from HCIA. After profiling, MAG works with physicians and PHOs to design utilization improving interventions. HCIA describes Peer-A-Med® as software that "has been widely utilized for nearly a

"This is the most comprehensive organization of its type. Physician groups may receive a portion of our services from other companies, but they simply cannot receive the vast range of services that **MAG** offers anywhere else in Michigan."

-Krishna K. Sawhney, MD, MAG chair and MSMS president elect

decade throughout the health care industry to better understand physician behavior, lower the costs of medical care, and ultimately improve the quality of care." Through a special partnership, Peer-A-Med® is available in Michigan exclusively to MAG—just another example of the progressive thinking that MAG embodies.

MAG also is using technology to better serve clients and potential clients via the Internet. A complete Webpage redesign is underway (at time of printing), and MAG expects that the new site will be able to present all of the information their clients need, in an efficient and secure manner. "Maintaining our organization at the forefront of technology is one of the most effective ways to keep our clients at the forefront of health care," says Schwartz.

In the coming years, health care experts predict that managed care will evolve to become more efficient. The professionals at MAG are working diligently to ensure that Michigan physicians play an instrumental role in Michigan's health care evolution.

For more information regarding MAG services, please contact Kevin Cawley at MAG at (517) 336-1400 or kcawlev@mimed.com or Larry Schwartz at (517) 336-1400 or lschwartz@mimed.com.

The author is a Communications Specialist at MSMS. This article is part one in a series regarding MAG. Be sure to see part two in the May 1999 issue of Michigan Medicine. Or, find the article on MSMSNET, www.msms.org.

1999 TOPIC

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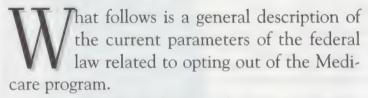
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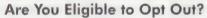
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## Is it Possible to "Opt Out" of the Medicare Program?

By Charles Cuzydlo, JD



Section 1802 of the Social Security Act, as amended by section 4507 of the Balanced Budget Act (BBA) of 1997, permits a physician or practitioner to enter into private contracts with Medicare beneficiaries to provide covered services, if specific requirements are met.



Currently, HCFA is requiring that a physician or practitioner (physician assistant, nurse practitioner, clinical nurse specialist, etc.) who has signed an agreement to participate in Medicare to terminate that agreement at the end of a calendar year before he/she may opt out of Medicare during the next calendar year. For example, a participating physician or practitioner who signs or automatically rolls over a current year participation agreement during the 1998 enrollment period cannot exercise the private contracting option; i.e., "opt out" in

Physicians and practitioners who reassign benefits to organizations that participate in Medicare (such as their employer, a facility whose services are provided or a health care delivery system) may not "opt out" because they are bound by the participation agreement signed by the organization that bills and is paid for their services. In order for the physician or practitioner to "opt out" of Medicare, either the organization must terminate its participation agreement or the physician or practitioner must terminate the reassignment of Medicare benefits to the organization.



#### Non-Covered Services

With respect to non-covered services a private contract is unnecessary and section 4507 does not apply. In other words, beneficiaries continue to be able to pay for any services that Medicare does not cover out of their own pockets, under the payment arrangement they make with their physician, without having to enter into a private contract subject to the provisions of section 4507.

#### **Private Contracts**

As provided in section 4507 of the BBA of 1997, a "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for all covered items and services he/ she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

Both parties must sign the private contract before services can be furnished and it must plainly and unambiguously state that by signing the private contract the beneficiary or the beneficiary's legal representative:

- Gives up all Medicare coverage of, and payment for, services furnished by the "opt out" physician or practitioner
- Agrees not to bill Medicare or ask the physician or practitioner to bill Medicare
- Is liable for all charges of the physician or practitioner, without any limits that would otherwise be imposed by Medicare
- Acknowledges that Medigap will not pay toward the services and that other supplemental insurers may not pay either

Acknowledges that he/she has the right to receive services from physicians and practitioners for whom Medicare coverage and payment would be available

The contract also must indicate whether the physician or practitioner has been excluded from Medicare. Finally, a contract is not valid if it is entered into by a beneficiary or by the beneficiary's legal representative when the Medicare beneficiary is facing an emergency or urgent health situation.

A physician or practitioner may not have private contracts with some beneficiaries and not others. The physician or practitioner who chooses to "opt out" of Medicare may provide covered care to Medicare beneficiaries only through private agreements, regardless of who bills and is paid for the services. To have a private contract with a beneficiary, the physician or practitioner must "opt out" of Medicare and file an affidavit with all Medicare carriers to which he/she would submit claims, advising that he/she has "opted out" of Medicare. The affidavit must be filed within ten (10) days of entering into the first "private contract" (as discussed above) with a Medicare beneficiary.

As with the "private contract" the affidavit, to be effective, must meet certain criteria. To properly opt out, the affidavit must:

- Provide that the physician or practitioner will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the two (2) year period beginning on the date the affidavit is signed
- Provide that the physician or practitioner will not receive any Medicare payment for any items or services provided to Medicare beneficiaries
- Identify the physician or practitioner sufficiently that the carrier can ensure that no payment is made to the physician or practitioner during the "opt out" period. If the physician has already enrolled in Medicare,

- this would include the physician or practitioner's Medicare uniform provider identification number
- Be filed with all carriers who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare and must be filed no later than ten (10) days after the first private contract to which the affidavit applies is entered into; and
- Be in writing and be signed by the physician or practitioner

As to your question of who can "opt out" physicians and practitioners may "opt out" of Medicare. For purposes of this provision, physicians include doctors of medicine and of osteopathy. Practitioners include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, and clinical psychologists. However, the law does not define "physician" to include optometrists, chiropractors, podiatrists, dentists, and doctors of oral surgery; therefore, they may not opt out of Medicare.

The author is chief of legal and regulatory affairs at MSMS.

#### For Further Information

For further information, please contact Charles R. Cuzydlo, JD, MSMS chief of Legal and Regulatory Affairs at (517) 336-5714 or ccuzydlo@msms.org. Or check out our Website at http://www.msms.org.



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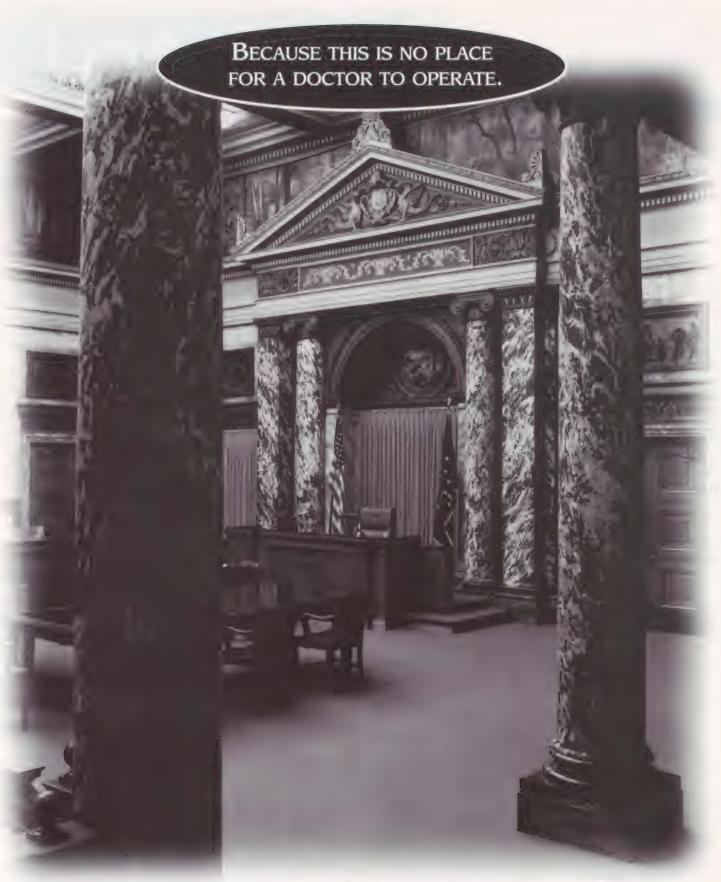
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## Issues Brief Medicaid

#### Introduction

The Medicaid portion of Governor John Engler's FY1999-2000 budget proposal announced at the end of February is severely inadequate to ensure access to health care for patients covered by the Michigan Medicaid program. The proposed \$7.8 billion budget for the Michigan Department of Community Health (MDCH) includes only a 4% increase in funding to Medicaid Qualified Health Plans, or about \$48 million.

It is unclear how much of that scant increase will reach physicians caring for Medicaid patients. In fact, there is no guarantee that any of the increase will be utilized for direct patient care. Furthermore, the House Appropriations Subcommittee on Community Health cut the original budget recommendation of a 3% increase for fee-for-service to just 2.2%. This would result in an increase of just 43¢ to the current \$19.40 conversion factor, the base from which a capitated rate is developed.

Estimates indicate that it would require at least an additional \$120 million - earmarked for physician

services - simply to reimburse at a rate equivalent to the cost of providing medical

care to Medicaid patients.

**Average Operating Cost** per Onsite Non-Surgical **Encounter:** \$31.13

Michigan's Average **Reimbursement Rate for Non-Surgical Encounters:** \$20.60

Michigan ranks at the bottom 10% in the nation for physician reimbursement.

> **National Average of** Reimbursement for Services: \$25.12

**Conversion Factors** in Michigan:

> Medicaid \$19.40

> Medicare \$34.73

**BCBS** \$40 - \$50 **Funding the Medicaid System** 

No funding increase has been made in the Medicaid system since 1991. In fact, when MDCH and the Michigan Legislature ended the previously effective Physician Sponsor Plan in favor of Medicaid managed care in 1996, an immediate savings of \$110 million was "realized," then removed from the MDCH budget during that first vear.

#### **Direct Patient Care**

Currently, many physicians are asked to provide quality health care to patients at a rate as low as \$5 per patient per month. This low rate makes it very difficult for a physician to provide quality care – not to mention preventative health care – to Medicaid patients.

As of 1996, Michigan ranked 40th in the nation in terms of physician Medicaid reimbursement. According to a study by the American Group Practice Association, Michigan continues to reimburse physicians at a rate less than the actual cost for providing medical services. For example, the actual U.S. average operating cost per onsite non-surgical encounter is \$31.13. This number includes practice costs such as office rent and non-physician staff wages. Michigan's average Medicaid reimbursement rate under the fee-for-service program for a non-surgical encounters is \$20.60. This rate is less than two-thirds of the actual cost for providing those services.

#### **Timely Payment for Services**

Physicians also are finding that many qualified health plans do not pay medical claims in a timely manner. This means that a physician provides the medical service for a Medicaid patient, bills the health plan for the service, then may not receive payment for those services for up to one year. At least two health plans have not reimbursed physicians since April 1998. Physicians can prove they have submitted perfectly clean claims and the health plans are not arguing that fact. They simply have not paid the physicians. Many other specific examples exist.

MSMS is pleased that the House Appropriations Subcommittee on Community Health's proposed budget requires health plans to resolve timely payment problems. If any one plan does not comply with the requirements, all qualified health plans will lose any increase in funding in FY 2000. Therefore, if health plans do not pay in a timely manner, they risk losing up to \$48 million in funding. Clearly, this will impact health plan claim payment responsiveness.

According to the Social Security Act (SSA) 1902 (a) (37), the state of Michigan has a responsibility to Medicaid recipients to encourage provider participation by paying providers in a timely manner. The state must pay 90% of all undisputed claim claims (i.e. complete and error free) within 30 days, 99% within 90 days, and the balance within 12 months. If the state fails to satisfy these standards, the state's plan to participate in Medicaid is invalid.

MSMS believes the state of Michigan has failed to ensure that its qualified health plans are reimbursing physicians in a timely manner.

#### **Costly Bureaucratic Burdens**

Not only are physicians reimbursed below the cost of providing services to the Medicaid population, but the cost of providing services to Medicaid patients actually is higher due to the bureaucratic burdens involved.

For example, Medicaid qualified health plans often require prior authorization to provide medical services. Therefore, a physician or a member of the physician's staff must spend a great deal of time on the telephone with health plan employees to obtain authorization for a medical service. Added paperwork required by the various health plans and frequent letter-writing to seek authorization for a particular service compound time-consuming bureaucratic burdens. MDCH also requires reporting of certain information, which consumes even more time and resources.

#### **Moving Forward**

MSMS stands ready to work with lawmakers and the administration to address all issues concerning the Medicaid program. MSMS believes this must be a team effort involving the best resources of physicians, health plans, hospitals and the state of Michigan as the budget process moves from the House into the Senate and, ultimately, back to Governor Engler.

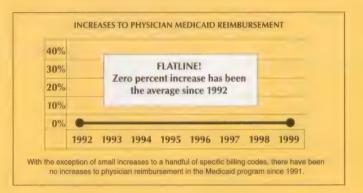
As one physician noted, "In order for the Medicaid system to work, it must work for all parties involved...patients, providers and the state. It can't just work for the state."

For more information about the Medicaid access crisis, contact Gregory Aronin, MSMS director of Government Relations, at 517-336-5739 or garonin@msms.org, or Christine Shearer, chief, State Government Affairs, at 517-336-5737 or cshearer@msms.org.

#### State's Responsibility to Assure Access to Quality Medical Care

Under SSA 1902 (a) (30), the state is responsible to assure that Medicaid Recipients have access to quality medical care. The State is required to adopt reimbursement methods and procedures which satisfy both of the following:

- (1) Assure that provider reimbursement is consistent with efficiency, economy, and quality of care; and
- (2) Are sufficient to enlist enough providers so that Medicaid recipients have at least the same access to health care services as the insured population.



#### **MSMS Task Force** on Medicaid Access - Statement of Purpose -

Our goal is to secure appropriate and adequate funding of the Michigan Medicaid program that will ensure access to care and the quality of that care for our Medicaid-eligible patients. Our strategy is to educate the media, public and legislators about the critical underfunding of the state's Medicaid program, a situation already creating severe problems with access to care and quality of care. Methods will include physician and patient testimony at the Legislature, a public relations campaign and a thorough examination of the state's legal responsibility for adequately funding the Medicaid program.

## Medicaid Issues Brief

### PHYSICIAN REIMBURSEMENT BY CPT CODE

In Michigan,
fee-for-
service
eimbursement
for six
common
procedure
codes ranks
in the
nation's
bottom 10%.
In fact,
Michigan
eimbursement
rates rank
just above
those
of
Mississippi.

State	99201	99202	99203	99211	99212	99213	Average					
Alabama	25.00	37.00	50.00	12.00	21.00	30.00	29.14					
Alaska	54.29	65.41	79.30	26.23	37.74	49.87	52.14					
Arizona	29.39	46.50	63.98	14.14	25.30	35.71	35.83					
Arkansas	27.00	41.00	59.00	13.00	25.00	33.00	33.00					
California												
Colorado	18.69	29.73	40.11	11.41	20.81	29.17	24.98					
Connecticut	Did not re	espond to requ	ests for inforn	nation								
Delaware	20.00	28.00	60.00	12.50	20.00	39.00	30.75					
Florida	30.00	31.77	43.39	12.00	21.00	25.00	27.19					
Georgia	29.78	45.34	51.08	13.82	24.75	34.82	33.26					
Hawaii Reimbursed by each physician's usual fee up to 75th percentile in specialty												
Idaho	26.02	35.96	46.54	20.88	26.81	31.32	31.25					
Illinois	20.35	20.35	25.05	7.80	8.00	8.00	14.92					
Indiana	20.82	33.96	46.85	13.23	18.20	25.98	26.50					
lowa	20.06	30.12	33.47	13.39	18.39	21.05	22.74					
Kansas	15.00	17.00	25.00	11.24	15.00	17.00	16.70					
Kentucky	20.39	32.77	44.90	9.81	17.55	25.03	25.07					
Louisiana	22.00	30.00	36.00	14.00	23.00	27.00	25.00					
Maine	15.65	16.82	24.77	12.70	15.65	20.36	17.65					
Maryland	25.00	33.00	37.00	10.00	20.00	31.00	26.00					
Massachusetts	21.85	32.20	47.15	10.35	21.85	33.54	27.82					
Michigan	16.88	26.58	35.89	8.73	14.55	21.00	20.60					
Minnesota	26.40	29.60	35.20	12.00	20.00	24.00	24.53					
Mississippi	17.60	24.50	31.33	9.49	15.39	20.16	19.74					
Missouri	15.00	15.00	20.00	5.00	10.00	17.00	13.00					
Montana	31.46	39.70	42.33	13.60	20.00	23.39	28.41					
Nebraska	21.13	30.88	45.50	11.38	19.50	29.25	26.27					
Nevada	29.44	37.92	52.40	17.47	28.44	32.44	33.01					
		30.00					24.00					
New Mexico												
New York	7.00	27. <b>95</b> 11.00	11.00	7.00	11.00	11.00	9.00					
North Carolina	22.68	36.97	50.20	11.04	19.95	28.12	28.24					
North Dakota	26.91	34.42	47.97	12.00	16.38	25.04	26.45					
							21.74					
Ohio	16.12 17.75	25.79 28.33	35.46	9.21	17.86	25.11	20.93					
Oklahoma			34.97 42.75		14.46	20.91	23.94					
Oregon	19.48	31.35		9.50	16.86	23.75						
Pennsylvania	20.00	20.00	20.00	20.00	20.00	20.00	20.00					
Rhode Island	16.72	27.24	27.24	8.05	26.64	26.64	20.08					
South Carolina	30.00	30.00	30.00	5.50	21.50	21.50	23.08					
South Dakota	23.80	37.20	49.00	11.70	19.10	28.70	28.33					
Tennessee		through man			10.55	0/	07.2					
Texas	22.30	35.20	47.57	11.56	19.35	26.87	27.14					
Utah	18.17	29.21	40.02	8.74	15.64	22.31	22.34					
Vermont	17.20	23.30	33.20	13.50	22.10	25.80	22.51					
Virginia	20.00	25.00	27.00	5.00	15.00	21.90	18.98					
Washington	20.64	32.66	44.94	9.93	17.76	25.08	25.16					
West Virginia	21.11	33.98	46.59	Not Covered	18.28	26.00	29.19					
Wisconsin	19.90	22.37	24.86	10.77	19.60	26.84	20.72					
Wyoming	23.90	37.33	50.98	12.38	20.74	28.80	29.08					

#### REIMBURSEMENT FOR MEDICAL PROCEDURES

СРТ	Description	Michigan BC/BS	Michigan Medicare	Michigan Medicaid
99201	Initial office visit for a 10-year-old male, for limited subungual hematoma not requiring drainage	\$37.00	\$32.23	\$16.88
99202	Initial office visit for a 13-year-old patient with comedopapular acne of the face unresponsive to over-the-counter medications	59.37	50.42	26.58
99203	Initial office visit for a 44-year-old male with painless gross hematuria without cystoscopy	82.60	69.27	35.89
99211	Office visit for a 50-year-old male, established patient, for a removal of uncomplicated facial sutures	16.35	14.27	8.73
99212	Office visit of a child, established patient, with chronic secretory otitis media	32.27	27.44	14.55
99213	Office visit for a 62-year-old female, established patient, for follow-up for stable cirrhosis of the liver	46.46	39.28	21.00
93012	EKG	106.26	92.16	4.66
55250	Vasectomy	289.51	219.62	138.26
21310	Nasal bone fracture without manipulation	61.09	51.30	35.93
76818	Fetal biophysical profile	114.85	100.90	58.39

The House Appropriations Subcommittee on Community Health's proposed budget would allow for only a 2.2% increase to physicians under the fee-forservice methodology. This would result in an increase of only 43¢ to the current \$19.40 conversion. factor.

An overview of the MDCH budget indicates that some portion of a possible 4% increase through the Health Plans could be allocated to physicians. Clarification is needed concerning what this possible 4% figure means.

If the entire 4% passed on to physician services, it would equate to a 78¢ increase to the current \$19.40 conversion factor. This is the base from which a capitated rate is developed.

### Pertinent Issues to be Evaluated

MSMS has conducted a great deal of research to better understand the problems that exist within the Medicaid program and to identify proper funding of the program. A great deal more detailed information needs to be made public, however. Questions that MSMS is investigating as the budget process continues follow.

- Has MDCH investigated how much the budget would have to be increased to ensure that physicians receive an amount equivalent to Medicare reimbursement?
- Do any state agencies have statistics on the percentage of medical claims that each Medicaid qualified health plan pays in a timely fashion?
- Has MDCH, or any other state agency, looked at its funding of the Medicaid program compared to the health care inflation rate, or have Medicaid reimbursement rates ever been compared to the average operating costs of physicians?
- Has MDCH looked into a means of ensuring that a certain percentage of the Medicaid payments to qualified health plans is used for direct patient care?

- Has MDCH looked into the impact of the added benefit mandates on the ability of health plans to efficiently provide medical coverage?
- Have the additional reporting requirements been evaluated from a cost perspective, considering the time it takes away from direct patient care?
- Has MDCH evaluated—from a cost perspective the additional paperwork and telephoning required under the Medicaid managed care system due to the various claims forms, the different requirements for approving health care services and additional reporting requirements?
- What figures did MDCH use in determining a three to four percent increase (\$7 million) in the budget for physician services as sufficient to maintain access to quality medical services for the Medicaid population?



# The Truth about Mergers and Acquisitions

Recommendations for Physicians in a Dynamically Changing Health Care Environment

By Ralph D. Ward

Merger and acquisition issues have been a business flashpoint for two decades as noted business names have disappeared, millions of jobs have been cut, and fortunes have been made—or lost—by savvy merger and acquisition dealings. While physician practice mergers and acquisitions lack the headline potential of Daimler merging with Chrysler, the pitfalls above still may apply.

"This has become a serious physician issue over the last few years, particularly as it relates to managed care."

-Kenneth Musson, MD, Chair, MSMS **Board of Directors** 

ractices that have built a reputation over the years do disappear, bringing uncertainty both to patients and staff. The job cuts won't add up to millions, but they will dislocate office staff that may have worked with a physician for years, and those that remain may need new skills. Finally, there definitely is money to be made by physicians who merge wisely. But there also are too many cases of physicians left holding the bag, losing patients to the new entity, and feeling cut off from their former sense of power.

"This has become a serious physician issue over the last few years," notes Kenneth Musson, MD, Chair, MSMS Board of Directors. "Particularly as it relates to managed care. There's an impression that bigger is better and more efficient, so consolidation must mean survival in a managed care world. But we're finding out that this is not necessarily true." Indeed, as the number of practice mergers and acquisitions climbs, we're learning that much of the popular wisdom on practice merger and acquisition is wrong. Some of the benefits of merging your practice prove elusive. And being acquired can offer some unsuspected payoffs.

### A Terminology Lesson

First, we should pin down our terminology. A medical practice merger typically involves the consolidation of two or more practices or groups into a new entity, ideally with the physician who joins the entity maintaining a proportionate share of power. In an acquisition the physician or group sells the practice outright, typically becoming an employee of the entity.

Although there are any number of good or bad outcomes from either scenario, many physicians view a merger as the more positive, allowing them to keep a say in the ongoing practice. To be acquired, though the payoff can often be handsome, still smacks of coming out the loser in an eat-or-be-eaten contest. "People often decide to merge multiple practices together for sound business reasons," notes Mary Anne Ford, MSMS general manager of subsidiary services. "But in others, the sale factors may seem outside the control of the physician."

To help sort out the good from the bad, MSMS recently commissioned a study of physician practice mergers by health care consultant, Policy Planning Associates. Six group practices of various sizes, practice areas, and regions of the country were examined for the merger goals sought, how well they were achieved, and practice issues that arose. Key points of the study are offered below. Tom Gorey, ID, president of the Illinois-based firm, sums up the findings: "generally, physicians were very pleased with their mergers." But there also remained room for improvement.

#### Market Influence

The rise of managed care seems to reward market mass, and physicians often consolidate to increase their clout. Greater negotiating power, geographic coverage, and practice infrastructure can strengthen their hand in dealing with managed care and hospitals. "When there's a sudden increase in managed care in a market, physicians begin to feel the pressure," observes Gorey. "They feel that if they don't make a move, and quickly, that there will be few independents left." While this "critical mass" can pay off, consolidation also can trigger a frenzy to pair up while the pairing is good without time for proper due diligence and full weighing of the plusses and minuses.

### Compensation and Benefits

These can often be make-or-break negotiating issues in mergers, the study found, with physicians fighting hard to get the pay and perks they feel they've worked for. At the very least, physicians don't want to lose out in the merger or acquisition process, but the study found they also must consider how future pay and benefit changes will effect them. "Look closely at the

pension plans," cautions Erik Lindquist, of Mid Michigan Physician's Group, one of the groups in the study. "This can be one of the biggest sticking points. One of the largest fears in the physician's minds is whether the future for themselves and their staff is protected."

Iim Aluia, who works with Medical Advantage Group, a noted "practice marriage broker," agrees. Too often, he sees the clashing benefit packages of office staff as a merger factor that's left to be muddled through after the ink is dry. Physicians "spend a lot of time on the financial arrangements, but then forget about things like rationalizing benefits." Employees find that "Gee, Doc A gives full health, dental, and pension benefits, while Doc B gives six holidays a vear."

### **Physician Autonomy**

If your practice is acquired by a group or hospital, you can be sure of losing the autonomy you enjoyed while on your own. But the MSMS survey found that mergers also result in a loss of power by the individual physician, though often the doctors could have negotiated for greater clout. "You should still want to be heard, so shoot to come in as a partner," counsels Aluia. "If you join with five others, arrange to have each of you with a sixth in the group's governance."

Aluia recalls a multi-specialty group that came together well, but failed to carefully define its governance structure. "After the honeymoon, they voted one physician to serve as leader, and he quickly began making all the decisions. Soon the other physicians were all asking themselves how this happened." The MSMS study found that newly formed groups often try to avoid such problems with a strong representative board of all the physicians involved. While this works as democracy, the board, if large, tends to prove unwieldy over time. Such representative group boards often shrink as the members grow more comfortable

with yielding autonomy over to the group.

#### Administration

A crucial finding of the study was that a "step up" in the quality of practice administration is demanded by a merger, not just a pooling of the current staff. A qualified executive director and support staff is crucial for success, and members of the pre-merger physician staffs may not have the skills demanded. Shifting current staff into the new office can be like the furniture situation after marriage—you have two of everything, but none of some new things that you may very much need. "Most groups formed through the merger of solo or small practices just didn't have the professional administrators they needed," says Gorey.

It's also wise to shape formal administrative policies and procedures during the pre-merger process. These often were not needed in the smaller individual practices, but can get the newly merged practice off on good footing.

### Office Staff

Unfortunately, the above problem of teaching old dogs new tricks fuels the often-serious turf problems office staff face in adapting to the new regime. Rick DeNardo, MD, who heads up the new three-physician Michigan Cardiology PC in Flint, sees such personnel problems as one of the few flaws in merging their highly successful joint practice. "We merged several office staffs, and there were some initial, unanticipated staff problems. The fact that this would be a different type of practice required some transition. People were ingrained in their old ways of doing things." Office staff who were comfortable in their well-defined roles must suddenly fit in with others who may have the same—or better—qualifications, which leaves plenty of room for turf battles, bruised feelings, and uncertainty. Staff turnover is often high in the months immediately after the merger as those who cannot adapt leave.

"People often decide to merge multiple practices together for sound business reasons."

-Mary Anne Ford, MSMS general manager of subsidiary services.

"Most groups formed through the merger of solo or small practices just didn't have the professional administrators they needed."

-Tom Gorey, president, Policy **Planning Associates** 

### Strategic Development

While there is a legal golden moment when a merger formally takes place, the study found that a merger is less a single event than an ongoing process. A good practice merger can take years to effectively meld together, with ongoing issues of pay, power, governance, and strategic direction. The latter is particularly important to make the "endless merger" effective.

The strategic goals and mix that brought the merged entity into being will remain ever-moving targets. The size, practice mix, geography, personnel, and affiliations in effect at the moment of merger, even if ideal, will not stay the best blend for long in the fast-moving world of modern health care. "It's important to plan well," observes MSMS Board Member John MacKeigan, MD, a Grand Rapid colorectal surgeon and veteran of several mergers. "Merge for a long-term strategy, not because of a shortterm crisis." Ralph Boyk Jr., administrator with Michigan Cardiology in Flint, agrees: "ask yourselves where the market will be in five years, and ten years, and how you can align with other doctors to meet those needs."

### **Group Culture**

While good planning and good governance are important for a merger, nurturing a distinct "group culture" is needed for long-term success. In an ideal merger situation, the physicians would move into a new facility that had no associations with any of their individual practices. "My space vs your space" turf problems can then be avoided in a fresh, neutral setting. However, building ownership or long-term leases make such an ideal difficult.

On the other hand, locating physician offices in separate facilities, or even keeping them in their current location, weakens any effort to forge a shared culture—as well as keeping fixed costs high. "You have to feel comfortable with how the other physicians practice, and learn to make decisions in a group," counsels Aluia.

### The Acquisition Decision

While a practice merger offers the physician many tools for holding onto power, an acquisition—selling your practice outright—leaves the physician much more vulnerable. If the sale leaves you an employee of the new entity, the quality of your initial sale contract may be the only protection you'll have. "We've seen people get into contracts that are not to their advantage" warns MSMS Board Chair Kenneth Musson, MD. "Either they didn't take time to properly evaluate the contract, got bad advice, or got no advice at all." How can you avoid "signing your life away" in the acquisition process?

- Get good counsel throughout the negotiation process. MSMS and affiliates like Medical Advantage Group offer excellent counsel and resources for negotiating the best deal to protect your interests. "We have legal and business resources that offer very good expertise," notes Doctor Musson. "Physicians should take advantage of this as their starting point."
- "Try to avoid signing any more non-compete terms than you have to," counsels Jim Aluia of Medical Advantage Group. "Bear in mind that, even after your practice is acquired, you still have that [medical] license, and you can still practice."

"The separate cultures will always be different. especially when you're bringing a group of solo practitioners together."

### Market Response

The design of the newly merged practice is almost always a response to area market factors. The local progress of managed care, major employers, patient populations, and area hospitals and health systems will usually be either triggers for the merger, or strong influences in how it is shaped. But these forces then respond in turn to the new entity, and sometimes in unpredictable ways. Hospitals in particular are wild cards after the merger. The case study found that they can offer anything from "strong support to vehement opposition" depending on the politics of local health care. "Take time to analyze what the new practice hopes to accomplish," suggests Boyk. "Don't try to be everything to everybody."

Patients also may be uneasy about access to

their accustomed physicians unless a strong, positive information effort is made. "You can't overlook your patients," cautions Gorey. "Make sure to keep them informed, and keep the merger process transparent. If you let them know early how the merger will effect them, assuming it will at all, they'll be happier." "Feed back from our patients has been uniformly positive," says Doctor DeNardo about the Michigan Cardiology alliance. "The merger has allowed us to offer them better service."

### **Group Leadership**

The study found that special leadership qualities are needed among physicians involved to make the merger a success, but these talents may not be readily available among the initial group. Visionary medical leadership, able to articulate long-term goals and gain the respect of the group's other physicians, is needed to drive such major change. Some physicians may need to be sold on the benefits of a merger, requiring "Ask yourselves where the market will be in five years, and ten years, and how you can align with other doctors to meet those needs."

-Ralph Boyk Jr., administrator. Michigan Cardiology, Flint

- Don't be rushed. Both mergers and acquisitions can take on a "land rush" urgency in some markets, and physicians can feel pressured to sell while the selling is good. "When a hospital or practice management company starts acquiring, physicians can feel threatened," says Tom Gorey of Policy Planning Associates. "A bit of a crisis mentality can set in." But experts counsel that this attitude makes physicians too willing to settle for a less than ideal contract. Don't be afraid to play hard to get.
- Consider mergers as an empowering alternative. Some physicians who have sold their practices to hospitals are moving back in the other direction, merging out of the hospital

and in with other physicians as a way to regain power.

"I think you'll see more doctors coming together out of hospital-owned practices,' observes Ralph Boyk of Michigan Cardiology, and Rick DeNardo, MD, who left a hospital to form the practice, agrees. "This was empowering for me. In this day of managed care, it's increasingly difficult to be you patient's advocate, but this change allowed me to better protect my patients."

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"The major reason for unhappiness after a merger is being unrealistic about the results going in.... There is no pot of gold at the end of the rainbow-you'll still have to work hard for success."

-Krishna K. Sawhney, MD, MSMS president-elect salesmanship and organizational drive. "To motivate the merger process, and do it quickly and well, you need solid, visionary leadership," says Gorey "with physician leaders able to anticipate change."

### Merger Partners

Marry in haste and repent in leisure was another message of the MSMS merger case study. Most physicians seem to select partners well, based on previous professional relationships, past residency ties, and clinical reputation. Strong emphasis on the "cultural fit" noted earlier was another factor is success. But poor match-ups usually lead to a poor, troubled practice. "You must be very careful in the merger relationship," notes Krishna Sawhney, MD, MSMS president elect. "Who you work with is like a marriage, and if you don't get along with your partners, you're going to be miserable. Peace of mind in any such relationship is very important, so check potential partners out from A to Z."

#### Overhead

Everyone knows that merging will cut overhead costs and consolidate savings, right? If that's what everyone thinks, then everyone is wrong, the case study finds. Indeed, mergers typically *increased* immediate overhead costs. "Mergers cost money," notes Doctor MacKeigan, "and larger doesn't necessarily mean more efficiency in processes or costs."

Solo or small practices often have their penny-pinching ways down to an art, and may be quite cost effective to begin with. After the merger, the larger operation inevitably increases some costs, with more sophisticated information and diagnostic equipment often being required. Rather than cutting redundant staff, the new practice often retains them, while new staffers with more specialized (but also more expensive) talents may be required. The study found that the merged practice can indeed bring greater profitability, but that it is usually gained through better competitiveness, market clout, and clinical depth, rather than by shaving costs.

In summary, practice mergers and acquisitions can accomplish all of the positives you may seek in such a move—and also all of the negatives. An alliance can empower physicians, increase profitability, build clout in the local market, and improve long-term prospects. But it can also cost money, create frictions, and leave physicians feeling like a cog in a machine. Even the best of medial practice mergers will bring some of the negatives, but wise planning and realistic goals lessen the downside and make it more manageable. "The major reason for unhappiness after a merger is being unrealistic about the results going in," says Doctor Sawhney. "There is no pot of gold at the end of the rainbow—you'll still have to work hard for success."

The author is a Riverdale-based freelance writer.



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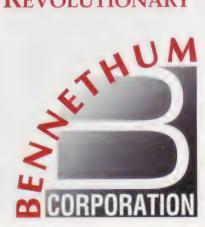
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# Patients' Rights Legislation

What to Expect in 1999

By Dustin May

he 106th Congress has wasted no time in tackling health care reform in its opening session. Over 10 pieces of legislation have been introduced that would extend basic rights to patients enrolled in managed care programs. Issues like "medical necessity" and the right of patients to sue HMOs will be considered. Because fundamental changes would occur in managed care plans, physicians must be aware of the legislation pending and make their concerns heard in Congress.

MSMS and the AMA are committed to passing patients' rights legislation this year as are the congressional leadership. Democrats and

> Republicans have indicated their willingness to work in a bipartisan manner to pass a form of patients' rights legislation this year. Although MSMS and the AMA are working to ensure that legislation contains language acceptable to physicians and their patients, it is imperative that physicians write, call, or fax their Congressmen and Senators to share their concerns and urge them to vote for legislation that protects patients' rights.

### Access to Quality Care Act of 1999

H.R. 216

Introduced by Congressman Charlie Norwood (R-GA)

ERISA—Allows health plans to be sued for treatment decisions resulting in injury or death

Access to Specialists— Permits women to obtain routine OB-GYN & pediatric care without referral. No specific access to other specialty care.

Medical Necessity and Internal/External Review— Internal review is 14 days/48 hours (exigent cases). Once plan receives all required information for coverage denial of excluded services, the enrollee may seek reconsideration, conducted by independent medical experts, not necessarily physicians.

Emergency Services—Contains "prudent layperson" standard.

### Patients' Rights Rhetoric

The politics of managed care reform often obscure the issues surrounding comprehensive reform. Many bills claim to be "patients' rights" bills, but few rise to the standards of MSMS and the AMA. Understanding the politics and language of this debate is crucial to following congressional deliberation. Not only do Congress and President Clinton have rhetorical power over this legislation, many business and insurance groups have lined up to preempt many important provisions of any proposed bill.

When President Clinton launched his Health Security Act

(HSA) of 1993, many Americans remember the television and news stories reviling his proposal. By using brilliant rhetorical strategy like the infamous "Harry and Louise" ads, many special interest groups fought to bury the HSA in a cloud of negative suspicion. Groups like MSMS and the AMA engaged in substantive debate, nevertheless, millions were spent to defeat comprehensive health reform.

Debate over managed care has intensified in recent years due to widespread media reports of higher premiums while denying treatments, convoluting appeals processes, and limiting access to emergency and specialty care. As a result of these abuses, the president, Congress, and organized medicine have worked together to build a solid proposal to reform managed care. Although this was a centrist position back in 1993, business and insurance lobbies have vowed to fight patients' rights bills this year in the same fashion, with rhetoric, not fact.

### **Cost Factors**

Many HMOs provide lower standards of care to their patients in the name of rising costs. In effect, protecting the moral obligation of physicians to provide quality care to their patients is secondary to profits. As a result of the fight

### Patients' Bill of Rights Plus Act

S. 300

Introduced by Senator Trent Lott (R-MS) ERISA— Does not remove ERISA preemption.

Access to Specialists—Requires selffunded group health plans to permit women to obtain routine OB-GYN & children pediatrics care without referral. No specific access to other specialty care.

Medical Necessity and Internal/External Appeals- Review of "internal appeal" of coverage is based on lack of medical necessity, must be made by "a physician with appropriate expertise." For external appeals, must meet significant financial threshold and must be based on decision related to medical necessity.

Emergency Services—Contains prudent layperson standard.

to maximize profit, many misleading statements will be made in the patients' rights debate this year. Claims will be made that imposing new regulations would dramatically increase the cost of health insurance forcing employers to either lower coverage for their workers or drop insurance altogether. This is a valid concern, but the fact is that costs will not rise to the exaggerated levels the managed care lobby predicts.

The most contentious and misunderstood issue of the patients' rights debate is that of the Employee Retirement Income Security Act of 1974 (ERISA), which protects managed care companies from being held liable when their treatment decisions adversely affect patients. This issue will define debate over any legislation. MSMS and the AMA believe that removing the ERISA preemption would force health plans to be accountable for their treatment decisions, ultimately protecting patients from the pressure to maximize profits.

### Patients' Rights Bills in Congress

MSMS and the AMA are committed to passing legislation giving patients the rights they deserve and the ability of physicians to serve these needs. Although they endorsed last year's Democratic "Patients' Bill of Rights," Richard

Deem, AMA vice president of federal affairs and coalitions, said that organized medicine is reserving endorsement of any particular bill for now. He added, referring to key provisions in any bill, "Our political goals are the same. We haven't backed away from anything. We want to encourage both (parties). I don't think at this point in time it's wise to get locked in."

In his State of the Union address on January 19, President Clinton called for action on a strong, enforceable Patients' Bill of Rights for all Americans. The President spoke on the need for all Americans to know their treatment options, not just the "cheapest." He appealed for choice of physicians, continuity of medical care, and access to specialty medical care. Further, he said that prompt access to needed emergency care should be guaranteed. The President implored Congress to seize the opportunity to extend these rights to every American.

### **Promoting Responsible Managed Care** Act of 1999

S. 374

Introduced by Senator John Chafee (R-RI) and Senator Bob Graham (D-FL)

ERISA—Does not remove ERISA preemption. Access to Specialists— Enrollee may choose an OB-GYN, a specialist familiar with enrollee's "ongoing special condition," or pediatrician for minors as primary care physician. Enrollees may go outside of plan for specialist if appropriate specialist within the plan is not available and accessible.

Medical Necessity and Internal/External Appeals—Defines "medical necessity" as "generally accepted principles of professional medical practice". Provides 30 day/72 hour (exigent care) deadlines for internal appeals and external appeals. Physicians must be part of all internal and external appeals relating to physicians' clinical decisions.

Emergency Services— Contains prudent layperson standard.

### Patient Protection Act of 1999

H.R. 448

Introduced by Congressman Michael Bilirakis (R-FL)

ERISA— Does not remove ERISA preemption.

Access to Specialists— Requires group health plans to permit women to obtain routine OB-GYN & children pediatric care without referral. No other specific access to specialty care.

Medical Necessity and Internal/External Appeals— Initial coverage determinations to be made within 30 days and urgent care 72 hours. Internal reviews do not require independent MD involvement with specialty expert. External review made by independent fiduciary, not prior involved MD. Plan definition of medical necessity always controlling at all levels of appeal.

Emergency Services— Covers only under emergency medical screening exams under prudent layperson standard. Subsequent emergency medical services governed by "prudent emergency medical professional" standard.

The AMA released a statement from Randolph D. Smoak, MD, chair of the AMA Board of Trustees, that applauds President Clinton's continued commitment to a strong Patients' Bill of Rights. "Every day we wait puts patients at risk." Doctor Smoak said, "With the President, Congress, patients, and physicians all working together, this important legislation can certainly be signed into law in 1999."

MSMS and the AMA believe that the following elements must also be included in comprehensive patient protection legislation:

 Prompt and fair redress through independent external review procedures

- Access to adequate information from the health plan
- Prohibition on gag practices and gag clauses
- Guaranteed prompt access to needed emergency care
- Ensured choice, continuity of medical care and access to specialty medical care
- Health plan accountability when their negligent medical decisions cause injury or death
- Stronger state laws should not be pre-empted by any federal patients' rights legislation

### **Managed Care Reform** Act of 1999

H.R. 719

Introduced by Congressman Greg Ganske (R-IA)

ERISA— Allows health plans to be sued for treatment decisions resulting in injury or death.

Access to Specialists— Enrollee may choose an OB-GYN, a specialist familiar with enrollee's "ongoing special condition," or pediatrician for minors as primary care physician.

Medical Necessity and Internal/ External Appeals— "Medical necessity" defined as "generally accepted principles of professional medical practice." Determination of medical necessity shall be made in external review process. Internal appeals decisions must be rendered within 30 days/72 hours (exigent cases). For external appeals, internal appeals must have been exhausted, and appeal must involve an amount exceeding \$100 or involve illness jeopardizing patient's life or health.

Emergency Services—Contains prudent layperson standard

### Congress Doesn't Waste Time

Democrats and Republicans wasted no time in drafting various proposals. As of February 12, 1999, over 14 patients' rights bills have been introduced. MSMS and the AMA are currently reviewing this legislation and working with Congress pass a comprehensive patients' rights

The legislation endorsed by MSMS and the AMA in the 105th Congress, H.R. 3605, the Patients' Bill of Rights, authored by Congressman John Dingell (D-Michigan), has been reintroduced as H.R. 358 without significant change. Congressman Charlie Norwood (R-Georgia) has introduced H.R. 216, AQCA: Access to Quality Care Act of 1999, the "sequel" to his PARCA legislation of the 105th Congress. Both of these bills contain an "ERISA" provision that would allow patients to sue their health plan for improper treatment decisions.

Also in the House, Congressman Greg Ganske, MD, (R-IA), has introduced H.R. 719, "The Managed Care Reform Act of 1999," which is seen as a compromise bill between the Republican and Democratic Leadership bills.

In the Senate, Senators John Chafee (R-RI) and Bob Graham (D-FL) introduced S. 374, the "Promoting Responsible Managed Care Act of 1999". This bipartisan compromise bill is very similar to the legislation Chafee and Graham introduced in the 105th Congress.

#### Resources

To get more information on patients' rights legislation, please utilize the following resources:

 MSMS Homepage(http://www.msms.org) Lists information about contacting Michigan's congressional delegation, Monthly Congressional Update, and Congressional Alerts.

### Patients' Bill of Rights Act of 1999

Introduced by Senator Tom Daschle (D-SD)

H.R. 358

Introduced by Congressman John Dingell (D-MI)

ERISA—Allows health plans to be sued for treatment decisions resulting in injury or death

Access to Specialists—When selecting a primary care physician, enrollee may choose OB-GYN or specialist familiar with enrollee's special condition, or pediatrician for minors.

Medical Necessity and Internal/ External Appeals— Medical necessity is defined as "generally acceptable principles of professional medical practice." Internal appeal decisions rendered within 30 days/60 days/72 hours (exigent cases). Treating MD must support external appeals.

Emergency Services—Contains "prudent layperson" standard.

AMA Grassroots Homepage (http:// www.ama-assn.org/grassroots): Lists current information about federal issues affecting organized medicine including updated Patients' Bill of Rights information.

For questions or information regarding this issue, contact Kevin A. Kelly, managing director, at (517) 336-5742, or kkelly@msms.org. Kristin Hartgrove, executive office intern, may also be of assistance at (517) 336-5783, or khartgrove@msms.org.

The author is an East Lansing-based freelance writer.

### 1999 Reference Guide to Michigan's Congressional Delegation

Congressional legislation that directly affects physicians is a political fact of life. MSMS has published this guide to Michigan's Congressional Delegation to help you contact your lawmakers quickly and easily.



Sen. Spencer Abraham R-Auburn Hills 245 Dirksen Bldg. Washington DC 20510 202-224-4822 michigan@abraham.senate.gov



Sen. Carl Levin D-Detroit 459 Russel Bldg. Washington DC 20510 202-224-6221 senator@levin.senate.gov



Cong. James Barcia
D-Bay City
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Washington DC 20510
202-225-8171
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Cong. David Bonior D-Mt. Clemens 2207 Rayburn Bldg. Washington DC 20510 202-225-2106 dbonior@mail.house.gov



Cong. David Camp R-Midland 137 Cannon Bldg. Washington DC 20510 202-225-3561 davecamp@mail.house.gov



Cong. John Conyers, Jr. D-Detroit 2426 Rayburn Bldg. Washington DC 20510 202-225-5126 iconyers@mail.house.gov



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Washington DC 20510
202-225-4071
public.dingell@mail.house.gov



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Washington DC 20510
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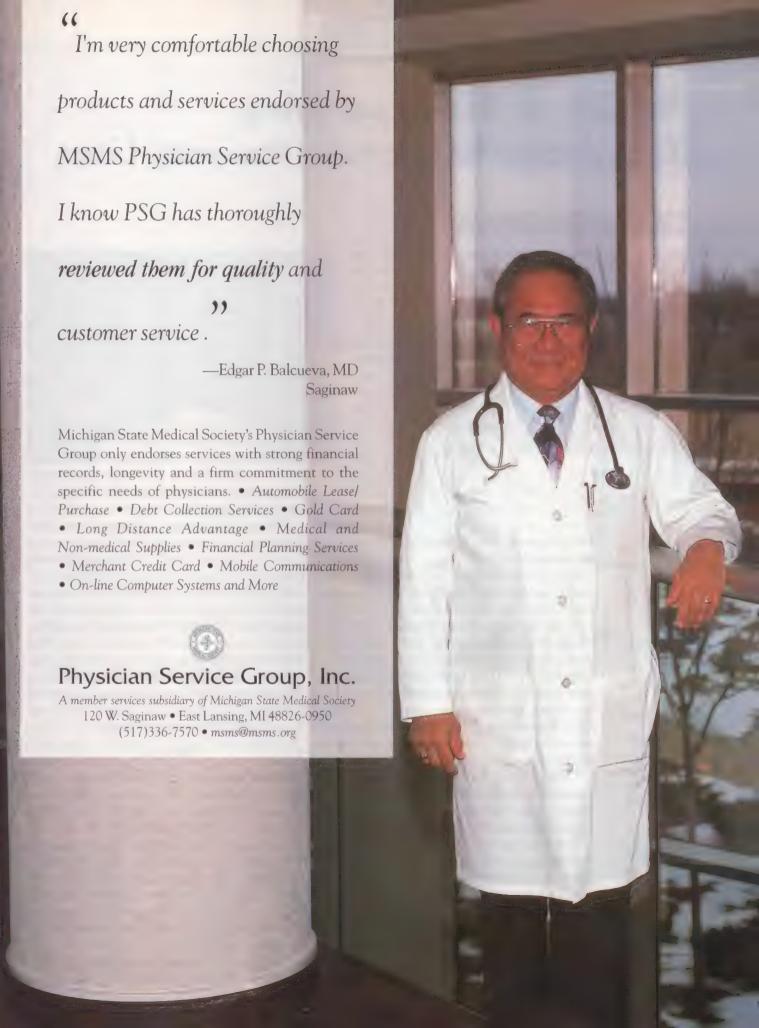
Cong. Bart Stupak
D-Menominee
2348 Rayburn Bldg.
Washington DC 20510
202-225-4735
stupak@mail.house.gov



Cong. Fred Upton R-St. Joseph 2333 Rayburn Bldg. Washington DC 20510 202-225-3761 talk2/su@mail.house.gov

### **Other MSMS Resources**

- For more information on communicating with your federal legislators, contact MSMS Managing Director Kevin A. Kelly at (517)336-5742 or kkelly@msms.org
- For email links to Michigan Congressional delegation, visit MSMSNet at http://www.msms.org. Go to: Political Action, Federal Government, Identify Your Federal Lawmakers.
- Refer to the handy MSMS Legislative Directory pull-out in the February 8, 1999 issue of Medigram.



## Physicians Use Experience, Knowledge to Improve Patients' Lives

By Steve Sternicki



She plans to give all profits from the book to charities that help the poor and disabled children in the **United States** and in thirdworld countries.

### Niru Prasad, MD: Keeping Children Safe and Healthy

After years of using all the usual medical tools to help her patients, Niru Prasad, MD, now has an unconventional one: a book.

With work recently completed on her first book, the Royal Oak-area pediatrician and emergency room physician is not stepping away from her first career, but has found a way to enhance it by publishing material relating to her specialties. Her handbook, How to Keep Your Child Safe and Healthy, incorporates material accumulated from her abundant experience in the field.

"I have seen a lot of parents come in with their children (with various ailments). I thought that by taking certain safety measures, some of these things could be avoided." Doctor Prasad feels that many health and safety problems occur because people are not prepared for them or don't recognize the dangers. She outlines some of these safety measures in the book, which is geared toward young mothers and caretakers of young children (age 0-2). The book provides suggestions for many situations that children face during this fragile period. She hopes the information will give caretakers an

understanding about some of the common child illnesses. "Yes, you will still go to the doctor, but you won't have to go for such things as a runny nose or sneezing. This book informs about the little things you can do at home."

Doctor Prasad, a mother of four adult children, has worked for three years to complete this project. She plans to give all profits from the book to charities that help the poor and disabled children in the United States and in third-world countries. Her time spent at Children's Hospital in Detroit, where she saw many disabled and underprivileged children, had a strong impact on her. "After helping for so many years as a physician, I feel this is the time I should give."

The book is the latest in Doctor Prasad's efforts to provide information and guidance to the public on health issues. She has published more than 100 articles with health topics in community newspapers and three articles in professional medical journals. Also, she hosts a weekly radio talk show, "Health Talk," on which she covers not only children's health issues, but adult and senior citizens topics as well. She has used the airwaves to inform listeners about her book project. "Once my book circulates to the bookstores, I will tell the public. I want my knowledge to be shared by everyone."

### Michael Rosenberg, MD: Diverse **Background Enhances New Position**

Decades of experience and knowledge from worldwide travels mark the package of skills Michael Rosenberg, MD, brings to his new position as carrier medical director of Michigan Medicare. For nearly 30 years, Doctor Rosenberg has practiced anesthesiology, and beginning in 1988, also was medical director of Sinai / DMC Surgery Center. As he takes on his new responsibilities, he will be looking to incorporate past-clinical experiences to carve an effective role. "I can provide insight into situ-



Busy at Work. Doctor Rosenberg is excited about his new position—carrier medical director of Michigan Medicare.

ations and can solve those problems from the perspective of someone who has been in there facing those problems. I have a good appreciation for what physicians, carriers, and patients have to deal with."

A Detroit native, Doctor Rosenberg has continued to make Michigan home, completing his medical education at Wayne State University and then practicing exclusively in the state since 1970.

Although Doctor Rosenberg chooses to ground himself in Michigan, he has a flair for traveling—and as often as his schedule allows. He visited several continents, often for pleasure but sometimes for medically related purposes, with his family. He finds learning about and seeing the medical practices in other countries puts the amenities of the United States into perspective. "It's useful to gain apprecia The author is an editorial Intern at MSMS.tion for what we have, and to see how lucky we are to have medical care we take for granted."

Particularly interesting for him was a trip to China he took a number of years ago before the Tiannenman Square incident in 1989. "People were extremely open and friendly."

While there, he learned, through visits to hospitals and presentations, the principles involved in the Chinese health system, which he says leans heavily on such things as acupunc-

ture and herbal medicine. "It serves an important purpose. Having such a large population, and taking care of so many people, it would be impossible to have a western-style medical practice. It works for them because that's what they are used to."

A pivotal time in Doctor Rosenberg's life was during his time in the Vietnam War, where he served in a MASH unit from 1966-68. When he was drafted into the army, he was actually a resident in OB/GYN, a classification that was soon to change. "They didn't need too many obstetricians, so they taught me to be an anesthesiologist. O.J.T.—on the job training; that's what they called it." His interest in the area grew during his time in the war. Despite this experience, he had to take a residency to become board certified upon returning to the States "I still had more to learn."

Several years ago, Doctor Rosenberg returned to Vietnam and visited many places, including the one at which he was stationed. "I wanted to see it as a country instead of a war. It's a beautiful country, when the bombs aren't exploding."

Doctor Rosenberg has a long list of places he still wants to visit. He hopes to find time in his new schedule to continue taking the vacations. He has reduced his clinical work but retains the amount of time he devotes to clinical teaching at Wayne State University. Just as he feels traveling has broadened him as a person, he feels the new position will bring him fulfillment. "I wouldn't take this position unless I thought it would broaden my horizon."

The author is a communications intern at MSMS.

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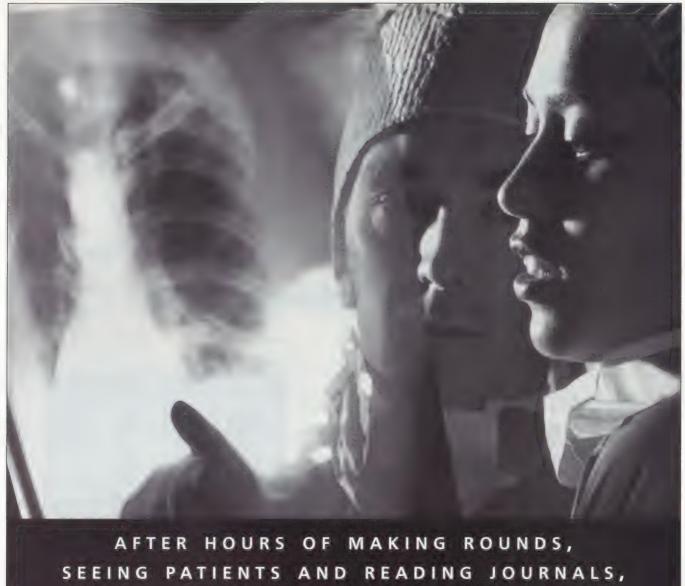


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The Foundation is a non-profit charitable organization sponsored by the Michigan State Medical Society. During the past several years, the Foundation has made wellness and healthy lifestyles a priority. The MSMS Foundation has provided grants recently to such worthwhile projects as: Oakland County anti-violence poster campaign • Drug education materials at downriver community teen centers • Tobacco-Free Kids Program in Mid-Michigan • Tutoring for dyslexic children in west Michigan • Upper Peninsula community health center materials • Wayne State University Institute for Gerontology • Michigan Fitness Foundation.

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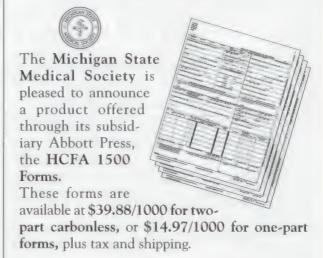
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### NEWSMAKERS



Thomas C. Royer, MD, was appointed chair of the Henry Ford Medical Group Board of Governors. Doctor Royer, of Bloomfield Hills, is responsible for strategic planning for the Henry Ford Medical Group and for facilitating relationships between the Henry Ford Health System and the more than 1,800 private practice physicians who provide care at Henry Ford facilities. This appointment marks his second five-year term as chair.

Robert Domeier, MD, was selected as medical director for Lansingbased Mobile Health Resources. Doctor Domeier, an emergency medicine physician, is also a flight physician with Midwest MEDFLIGHT and serves as a clinical instructor at the University of Michigan Medical School.

Daniel J. Reddy, MD, staff vascular surgeon at Henry Ford Hospital, recently was appointed head of the Division of Vascular Surgery. Doctor Reddy serves as program director for the general vascular surgery fellowship at the University of Michigan Medical Center. He also is a charter member and past president of the Michigan Vascular Society.



John Popovich, Jr., MD, recently has been appointed chair of the Department of Internal Medicine at Henry Ford Hospital. He has been acting chair of the department since July 1998. As chair, Doctor Popovich will oversee nine specialties..

Sam Kazziha, MD, recently was named medical director of Cardiac and Peripheral Intervention at Mount Clemens General Hospital. Doctor Kazziha is in private practice at Cardiovascular Consultants in Sterling Heights.

Kimberly Dawn Wisdom, MD, was recently honored by the Detroit City Council for her work with diabetes and the African American Community. Doctor Wisdom is staff investigator and emergency department physician at Henry Ford Health System. She also treats diabetes complications as an emergency department physician at Henry Ford Medical Center-Fairlane in Dearborn.

Shalini Chandra, chair of the Wayne State University - AMA/ MSMS Medical Student Section. was elected chair of Section V of the AMA-Medical Student Section. Section V is composed of medical students from schools in the states of Indiana, Kentucky, Michigan, Ohio, and West Virginia.

### **NEW MEMBERS**

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Mohammad Albaba, MD, Flint Anthony D. Barclay, MD, Okemos Michael J. Bauer, MD, Grand Rapids Mary E. Berman, MD, East Lansing Seth R. Bernard, DO, Grand Blanc Ruth Brandt, MD, Grand Rapids Jacqueline Chirco, DO, Washington Kyle Colvin, MD, Battle Creek Michelle L. Crooks, MD, Kalamazoo Charles A. Derrow, MD, Alma Seth Egelston, DO, Battle Creek Charles B. Evone, MD, Holland Abeer S. Fayyad, MD, Flint

Steven N. Glavas, DO, Muskegon Thomas E. Gribbin, MD, Grand Rapids Abdali Shakoor Jani, MD, Flint Shelly L. Kahler, MD, Dearborn Howard M. LeRoux, MD, North Muskegon Michael S. Lincoln, MD, Kalamazoo Jenn Yu (Kevin) Liu, DO, Haslett Peter J. Luea, MD, Lansing Kelli R. Lund, MD, Grand Rapids Mavnaro Luterman, MD, East Lansing Mark Mills, MD, Grand Ledge Leo R. Murskyj, MD, Warren Steven C. Naum, MD, Grand Rapids James Calvin Niewenhuis, MD, Battle Creek Karen S. Ogle, MD, East Lansing Ranganathan Parthasarathy, MD, Monroe Charles D. Rice, MD, East Lansing Daniel A. Rightmire, MD, Grand Rapids A. Nicholas Rizzo, MD, St Clair Shores Stanley Roland, DO, Lapeer Marilyn M. Rosa, MD, Flint Gail L. Smith, MD, Lansing John Joseph Stanley, MD, Monroe Mohammad Taki, MD, Flint Laura B. Terpenning, MD, Bay City Milos Tucakovic, MD, Flint Matthew L. Waack, MD, Bay City Steven Walczak, MD, Dearborn Bennett Willard, DO, Comstock Park

**OBITUARIES** 

Ratilal D. Bhakta, MD, died on January 13, 1999. He was 59. Doc-

tor Bhakta, an Allen Park internist, graduated from M.S. University in India in 1965. He was an assistant clinical professor of medicine at Wayne State University School of Medicine. Doctor Bhakta was a member of Physicians of India Association, American College of Cardiology, Wayne County Medical Society, AMA, and MSMS.

Thomas C. Blair, MD, died on January 10, 1999. He was 73. Doctor Blair, a Lansing cardiovascular surgeon, graduated from George Washington University in 1951. He served as a captain in the Air Force from 1953-55. Doctor Blair was an assistant clinical professor at Michigan State University. He was a member of Michigan Thoracic Society, Frederick Coller Surgeons Society, Society for Thoracic Surgeons, Ingham County Medical Society, AMA, and MSMS.

Mary Herlihy, MD, died on October 18, 1998. She was 56. Doctor Herlihy, a St. Charles general practitioner, graduated from University College of Ireland in 1966. She was a clinical instructor in the Department of Family Practice at Michigan State University. Doctor Herlihy was a member of Saginaw County Medical Society, Saginaw Family Practice, Saginaw County Medical Society, AMA, and MSMS.

LeRoy W. Juhnke, MD, died on December 9, 1998. He was 76. Doctor Juhnke, a Marshall obstetrician and gynecologist, graduated from Wayne State University School of Medicine in 1943. He served two years in the Army Medical Corps during WWII. Doctor Juhnke was a member of Lions Club International, Isabella-Clare County Medical Society, and MSMS.

Kenneth F. Porter, MD, died on December 12, 1998. He was 76. Doctor Porter, a Bloomfield Hills anesthesiologist, graduated from University of Western Ontario in 1952. He was a veteran of WWII. Doctor Porter was past chief of anesthesia at St. Joseph Mercy Hospital-Pontiac, a member of American Society of Anesthesiologists, Bloomfield Hills Rotary Club, Oakland County Medical Society, AMA, and MSMS.

Richard V. Wilson, MD, died in June 1998. He was 53. Doctor Wilson, a Novi obstetrician and gynecologist, graduated from Wayne State University School of Medicine in 1972. He was a member of Oakland County Medical Society, AMA, and MSMS.



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### DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Consumer and Industry Services, Office of Health Services.

Name: Sarveswara R. Cherukuri, MD, 27 Harvest Lane, Battle Creek, MI 49017

Action, Date Taken: 01-20-99; License Suspendedminimum 6 mo. & 1 day; Fine—\$500.00

Reason: Negligence/Incompetence Lack of Good Moral Character

Name: Byong-Du Choi, MD, 2826 Staten Ave., Lansing, MI 48910

Action, Date Taken: 01-20-99; License Permanently Limited; Fine—\$1,00.00

Reason: Violation of General Duty/Negligence

Name: Joon Young Choi, MD, 25430 Goddard Rd., Taylor, MI 48180

Action, Date Taken: 01-30-99; License Suspended-30days; Upon reinstatement, Probation-2 yrs.

Reason: Criminal Conviction

Name: Andrejs Dimants, MD, PO Box 189, Three Rivers, MI 49093

Action, Date Taken: 01-27-99; St. Joseph County Circuit Court granted motion for stay of enforcement and ordered reinstatement of license by 02-01-99. Reinstated w/Limited License & Probation until petition for review is adjudicated.

Name: Donald C. Jackson, Jr., MD, 200 Riverfront Pk. #18-A, Detroit, MI 48226

Action, Date Taken: 01-20-99; Probation-6 mo.; Fine-\$1,000.00

Reason: Negligence/Incompetence

Name: James W. Ledrick, MD, 7505 Aspenwood, S.E., Grand Rapids, MI 49546

Action, Date Taken: 02-13-99; Limited License-mini-

mum 2 vrs.; Probation-2vrs. Reason: Probation Violation

Name: Thomas S. McInernery, MD, 1695 W. 12-Mile Rd. #105, Berkley, MI 48072

Action, Date Taken: 02-19-99; Probation-1 vr. Reason: Violation of General Duty/Negligence

Name: James F. Beaudin, MD, 5989 Winans Lake Dr., Brighton, MI 48116

Action, Date Taken: 01-29-99; Reclassified w/Unlimited License

Name: Grmislav G. Drezga, MD, 1456 Hudson Rd., Hillsdale, MI 49242

Action, Date Taken: 02-28-99; License Revoked Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: Donovan H. Givens, Jr., MD, 19115 W. 8 Mile Rd., Detroit, MI

Action, Date Taken: 02-28-99; Reprimand; Fine-\$1,000.00

Reason: Probation Violation

Name: Salah E. Gouda, MD, 2119 15 Mile Rd., Sterling Heights, MI, 48310

Action, Date Taken: 01-29-99 Reinstatement Denied

Name: Alan A. Halpern, MD, 1700 S. Park St., Kalamazoo, MI 49001

Action, Date Taken: 03-03-99; License Reinstated; Probation-1 vr.

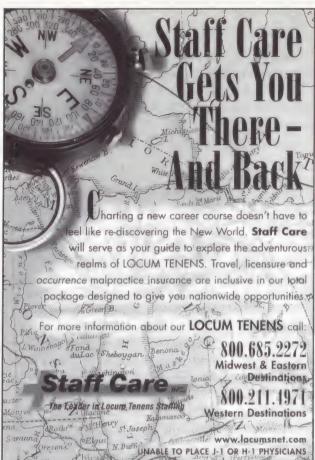
Name: Jose G. Higuera, MD, 80 Manchester Ave., Highland Park, MI 48203

Action, Date Taken: 02-28-99; License Suspendedminimum 6 mo. & 1 day; Fine—\$5,000.00

Reason: Negligence/Incompetence

Name: Carl L. Holsey, MD, 15 E. Kirby St., Suite 108, Detroit, MI 48202

Action, Date Taken: 01-29-99; License Reinstated; Probation-1 yr.





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### EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

### MAY

- 4, 11, Bar-Levay Educational Association Ongoing Seminar Series "How to develop a physician-like attitude in non-medical psychotherapists." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.
- 7, 27th Annual Cardiovascular Symposium. Location: Borgess Medical Center. Contact: MSU/ KCMS, Office of CME, 1000 Oakland Drive, Kalamazoo, MI, 49008-1284; or (616) 337-4611. Approved for: 5.5 Category 1 credits.
- 13, 22<sup>nd</sup> Annual Family Practice Research Day. Location: University Club of Michigan State University, Lansing, MI. Contact: Deb Misiak, Conference Secretary, MSU Department of Family Practice, at (517) 353-3544, ext. 424; or email misiak@pilot.msu.edu. Approved for: TBA
- 14-16, Managing Respiratory Diseases. Location: Hilton Resort, Hilton Head, SC. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.
- 14-16, Neurology for the Non-Neurologist. Location: Bally's, Las Vegas, NV. Contact: Linda Main,

- Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.
- 17-19, Mayo Clinic Nicotine Dependence Seminar: Counselor Training & Program Development. Location: Siebens Medical Education Building, Rochester, MN. Contact: Mayo School of Continuing Medical Education, 200 First St. S.W., Rochester, MN 55905; (800) 284-0532; or fax (507) 284-0532. Approved for: 24 Category 1 cred-
- 18, 25, Bar-Levav Educational Association Ongoing Seminar Series "The moral values of the psychotherapist: Can they, and should they, always be kept out of the therapeutic process?" Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.
- 19-20, Neurology Mini-fellowship. Location: Michigan State University, East Lansing, MI. Contact: Glen N. Ackerman, MD, A-217 Clinical Center, Michigan State University, East Lansing, MI 48824; (517) 371-3472; or fax (517) 371-5868. Approved for: 16 Category 1 credits.

### JUNE

- 1, 8, Bar-Levay Educational Association Ongoing Seminar Series "When intensive psychotherapy has ended: A look at the relationship of ex-patients with their extherapists." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.
- 11-13, Managing Respiratory Diseases. Location: Parc Fifty-Five, San Francisco, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.
- 15, 22, Bar-Levav Educational Association Ongoing Seminar Series "'Nervous habits': What they mean and the treatment they require." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.
- 17-19, Issues in Women's Health. Location: Hyatt Regency, Grand Cayman. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

18-20, Neurology for the Non-Neurologist. Location: Buena Vista Place, Orlando, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

24-26, Clinical Endocrinology for Primary Care Physicians. Location: Sonesta Beach Resort, Bermuda. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

25-27, Coronary Heart Disease Update. Location: Sheraton Fiesta Beach Resort, South Padre Island, TX. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

25-27, Dermatology for the Non-Dermatologist. Location: Hyatt Regency Alicante, Anaheim, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

29 & 7/6, Bar-Levay Educational Association Ongoing Seminar Series "A 'Healthy' Homosexual Lifestyle: Fact or Fiction." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

### JULY

9-11, Coronary Heart Disease Update. Location: Grand Hotel, Mackinac Island, MI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 cred-

15-17, Clinical Endocrinology for Primary Care Physicians. Location: Chateau Lake Louise, Lake Louise, Canada. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Issues in Women's Health. Location: Sheraton Hyannis, Cape Cod, MA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Neurology for the Nonneurologist. Location: Sagamore Resort, Lake George, NY. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 cred-

22-24, Managing Repiratory Diseases. Location: Hvatt Regency. Vancouver, Canada. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-25, Dermatology for the Nondermatologist. Location: Nemacolin Woodlands Resort & Spa, Farmington, PA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-24, 79th Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, MI. Contact: Paula Parshall, Continuing Medical Education, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386; (616) 935-6546; or fax (616) 935-7413. Approved for: 9-12 Category 1 credits.

### **MSMS** Meetings MAY

- 1, MSMS Michigan Society of Pathologists Meeting. Location: Greenfield Village, Dearborn, MI. Contact: Carrie Brock at (517) 336-7586 or cbrock@msms.org.
- 2, MSMS Board of Directors Meeting. Location: Ritz Carlton Hotel, Dearborn, MI. Contact: Irene Frost at (517) 336-5734 ifrost@msms.org.
- 2-4, MSMS Alliance Annual Meeting - House of Delegates. Location: Flint, MI. Contact: Liz Foster at (517) 336-7587 lfoster@msms.org.
- 4, MSMS Medical Business Specialist Program - "CPT-4 Coding: The Next Step." Location: Hampton Inn, Warren, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or imogyoros@msms.org.
- 6, MSMS Medical Business Specialist Program - "CPT-4 Coding: The Next Step." Location: WMU - Regional Education Center, Grand Rapids, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 6, Building a Compliance Program: Fraud and Abuse Seminar. Location: Harbor Holiday Inn. Muskegon, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 10-14, Working Toward A Lead Safe Michigan: Regional Confer-

- ence. Location: Marquette, MI. Contact: Childhood Lead Poisoning Prevention Project at (517) 335-8885.
- 11. MSMS Medical Business Specialist Program - "How to Collect for Control." Location: Troy Marriott, Troy, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or imogyoros@msms.org.
- 12, MSMS Medical Business Specialist Program - "How to Collect for Control." Location: MSMS Headquarters, East Lansing, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 12, Capitol Check-Up. Location: Radisson Hotel, Lansing, MI. Contact: Shannon Howard at (517) 336-5741 or showard@msms.org.
- 12, Closed Claim Review. Location: MSMS Headquarters, East Lansing, MI. Contact: Kristen Sabec (517)336-5769 ksabec@msms.org.
- 12, Leadership Skills Series: Health Care Negotiation and Conflict Resolution. Location: Dearborn Inn, Dearborn, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org. Approved for: 6.5 Category I credits.
- 13, MSMS Medical Business Specialist Program - "How to Collect for Control." Location: WMU -Regional Education Center, Grand Rapids, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or

imogyoros@msms.org.

- 13, MSMS/MICOA Closed Claim Review. Location: Saginaw, MI. Contact: Kristen Sabec at (517) 336-5769 or ksabec@msms.org.
- 17, MSMS Foundation Annual Golf Classic. Location: Country Club of Lansing, Lansing, MI. Contact: Judy Marr at (517) 336-5744 or imarr@msms.org.
- 18, E&M Tools, Tricks and Helpful Hints Workshop. Location: War Memorial Hospital, Sault Ste. Marie, MI. Contact: Jennifer Mogyoros at (517)336-7581 jmogyoros@msms.org.
- 19, MSMS Committee on Bioethics. Location: MSMS Headquarters, East Lansing, MI. Contact: David K. Fox at (517) 336-5731 or dkfox@msms.org.
- 19, MSMS/MICOA Closed Claim Review. Location: Ludington, MI. Contact: Kristen Sabec at (517) 336-5769 or ksabec@msms.org.
- 20, MSMS Medical Business Specialist Program - "ICD-9-CM Coding: The Next Step." Location: WMU - Regional Education Center, Grand Rapids, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or imogyoros@msms.org.

#### JUNE

1, MSMS Medical Business Specialist Program - "Medicare Part B - The Basics." Location: Hampton Inn, Warren, MI. Contact: Jen-

nifer Mogyoros at (517) 336-7581 or imogyoros@msms.org.

- 2, MSMS Medical Business Specialist Program - "Medicare Part B - The Basics." Location: WMU - Regional Education Center, Warren, MI. Contact: Jennifer Mogyoros (517) 336-7581 jmogyoros@msms.org.
- 3, MSMS CME Accreditation Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at 336-5727 or scressman@msms.org.
- 4, Michigan Society of Respiratory Care Board. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.
- 8, MSMS/MICOA Making the Rounds. Location: St. Joseph Hospital, Oakland, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@msms.org
- 11, MSMS HMO Medical Directors. Location: MSMS Headquarters, East Lansing, MI. Contact: Julie Lester at (517) 336-5768 or ilester@msms.org.
- 15, MSMS Committee on Aging. Location: MSMS Headquarters, East Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 15, Working Toward A Lead Safe Michigan: Regional Conference.

Location: Saginaw Valley State University, University Center, MI. Contact: Childhood Lead Poisoning Prevention Project at (517) 335-8885.

- 16, MSMS Committee on State Legislation & Regulations. Location: MSMS Headquarters, East Lansing, MI. Contact: Greg Aronin (517)336-5739 garonin@msms.org.
- 16, MSMS ASM Planning Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Mary Anne Ford at (517) 336-5721 or maford@msms.org.
- 16, MSMS ASM & CME Programming Joint Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at (517) 336-5727 or scressman@msms.org.
- 16, MSMS ASM & CME Programming Joint Reception and Dinner. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman and Mary Anne Ford at (517) 336-5727 scressman@msms.org.
- 22, MSMS Medical Business Specialist Program - "Risk Management for the Office." Location: Troy Marriott, Troy, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or imogyoros@msms.org.
- 24, MSMS Medical Business Specialist Program - "Risk Management for the Office." Location: WMU - Regional Education Center, Grand Rapids, MI. Contact: Jen-

nifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.

30, MSMS Committee on Bioethics. Location: MSMS Headquarters, East Lansing, MI. Contact: David K. Fox at (517) 336-5731 dkfox@msms.org.

### **SPECIALTY SOCIETIES** MAY

- 1, Michigan Society of Pathologists Meeting. Location: Greenfield Village, Dearborn, MI. Contact: Carrie Brock at (517) 336-7586 or cbrock@msms.org.
- 5-8, Michigan Chapter, American College of Surgeons. Location: Boyne Highlands. Contact: Carrie Brock at (517) 336-7586 or cbrock@msms.org.
- 12, Michigan Allergy & Asthma Society. Location: University of Michigan, Ann Arbor, MI. Contact: Melissa Wiegand at (517) 336-7599 or mwiegand@msms.org.
- 19, Michigan Society of Respiratory Care Pulmonary Rehab Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or lfoster@msms.org.

### AMA MEETINGS JUNE

20-24, AMA Annual Meeting. Location: Chicago Hilton, Chicago, IL. Contact: Judy Marr at (517) 336-5727 or jmarr@msms.org.

### Sci-Fi Review

#### By Roy Goodman, MD

arry Niven is responsible for so much of the best science fiction. He's written a few books that are merely good, and I don't especially care for his Man-Kzin wars series, but more of his work wound up on my list of all-time favorites than

The Mote In God's Eye by Larry Niven and Jerry Pournelle: A major failing of most science fiction is that the aliens aren't really alien; they're just guys in a different guise. Niven and Pournelle's "Moties" are truly different from humans, better than humans in a fascinating, imaginative way. Their biological imperative drives a compelling plot. You'll race through this one, reading it in every available moment, and you'll be sorry when ends.

The Legacy of Heorot by Larry Niven, Jerry Pournelle, and Steven Barnes: When I was a teenaged nerd, I used to devour Robert Heinlein's tales of heroism and self-sacrifice among the stars. Now I'm a middle-aged nerd, and I was bowled over by the modern equivalent. Heorot is tough-minded and exciting, with characters I cared about and a believable scientific basis.

Worlds Apart by Joe Haldeman: Stories of a devastated Earth are practically standard in science fiction, but nobody has brought one off as well. This book is the sequel to Worlds, which was very good but not quite as good.

Demons Don't Dream by Piers Anthony: I picked this one as representative of the Xanth fantasies and a good introduction to Piers Anthony in general; it's my favorite of the ones I've read so far, but the others range from enjoyable to excellent. Xanth is a unique creation, a world in which magic works and makes sense. often through ridiculous puns. Decency and loyalty count for everything in Anthony's writing, and his approach to sex is at once charmingly naive and admirably sensible.

Virtual Girl by Amy Thomson: All sci-fi readers are accustomed to robots that think like humans. This unusual creation follows the first such robot from boot-up and gives us a story about what it means to be human. Isaac Asimov's The Positronic Man likewise featured

the first robot with a real consciousness, but Virtual Girl is far and away the better novel.

King David's Spaceship by Jerry Pournelle: This is a short, simple tale of the heroism of ordinary people. The Ringworld Engineers by Larry Niven: Ringworld is an enormous artificial planet created by long-vanished super-science. Niven sends three ill-assorted travellers to its surface and runs them through a series of very entertaining adventures. This is the sequel; Ringworld is also well worth reading.

The Forever War by Joe Haldeman: My favorite piece of military science fiction, this is a short, (from the days before publishers started paying by the pound) tough story.

Time Gate edited by Robert Silverberg: What if computers could recreate the personalities of historical characters? This collection of short stories provides fascinating answers and forms a more-or-less unified tale. Another interesting approach to computer consciousness is The Silicon Man by Charles Platt.

Dream Park by Larry Niven and Steven Barnes: The facility of the title is the ultimate theme park, and the ultimate "ride" allows adventurers to really live a role-playing game. The book interweaves the technology, the excitement of a game, and a mystery, and all three stories race along.

The Flying Sorcerers by Larry Niven and David Gerrold: Two veteran sci-fi creators parody their genre. Like many good spoofs, this one has a perfectly reasonable plot—in fact the plot would have been quite satisfying if it had been written for serious. You have to be famil-



iar with science fiction to appreciate it, but if you are you'll find it a hoot.

Gather Darkness by Fritz Leiber: Advanced technology allows the powerful church to dominate a society deliberately kept in medieval backwardness, and advanced technology creates working "witchcraft" complete with familiars that I found unforgettable. This is a very clever, very nasty little book.

If some books stand out as excellent, a few others have been major disappointments:

The Gripping Hand by Larry Niven and Jerry Pournelle: I suppose this was a pretty decent book, but as the seguel to The Mote In God's Eye it doesn't compare to the original.

The Barsoom Project and The California Voodoo Game by Larry Niven and Steven Barnes: The authors return to Dream Park with interesting new technology and exciting new games, but without the plots to match. These are perfectly good books but not even close to the standard of the original.

Time Gate (volume 2): Dangerous Interfaces by Robert Silverberg: This collection of stories fails to capture the vitality of the original. (I don't dislike sequels just because they're sequels; you'll notice that two of my "best of" list are books that bettered their predecessors.)

Ender's Game by Orson Scott Card: Card is

an excellent writer, but I found this Hugo-winning novel despicable. The humans go to war because they don't understand the alien "Buggers," but Card doesn't bother to point out that there's no way they could possibly understand. And the humans are perhaps fighting unfairly and brutally, but since when is war supposed to be fair or gentle? If I had read this at the height of the Vietnam War I probably would have loved it, but now it's like a revisionist exhibit at the Smithsonian. Card's Wyrms is a fascinating but disgusting piece of bio-science fiction.

The Difference Engine by William Gibson and Bruce Sterling: The creators of cyberpunk take us to a Victorian England which has working computers—and then they pretty much forget about the computers! Their attempt to create a Victorian style results only in turgid prose, not a period feel.

Redshift Rendezvous by John E. Stith: How do you get from one star system to another in a practical time span? Stith creates a form of hyperspace which slows down the speed of light; since this extends to the inside of the spacecraft, it creates all sorts of interesting visual phenomena. Unfortunately, as in many recent movies, the plot doesn't measure up to the "special effects."

The author is a White Lake-based otolaryngolo-



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#### continued from page 64

As he says good-bye to all his friends, each shares a secret with him. One friend is a fox. The fox tells him, "'Now here is my secret. It is very simple. It is only with one's heart that one can see clearly. What is essential is invisible to the eve.' 'What is essential is invisible to the eye,' the little prince repeated, so as to be sure to remember."

What is essential in the Michigan State Medical Society is invisible to the eye, for it is you, your commitment and love for our profession and patients. It is those essential qualities and memories that I have gathered this year and which I shall carry with me always. For this very special opportunity, thank you.

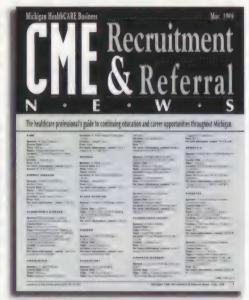
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#### "Thanks for the Memories"

By Cathy O. Blight, MD MSMS President



"This was the day I first met him...this the day I first loved him...this the day we married." Sitting in the Tower of London, awaiting her day with the executioner and having fashioned out slats of wood to mark those days. Anne Bolevn counted out the days of her life with Henry VIII in the movie "Anne of a Thousand Days." As I come to the end of my year as your president, I feel that, like Anne, I can count out each day of the past year (but, hopefully, without such dire consequences).

The year started with a grand celebration. The first few months literally sailed by. I was off being your voice and presence at many gatherings of county medical societies. specialty societies, and statewide allied health groups. Always, I was warmly received, in no small part because of the high esteem in which our state medical society is held.

But a blip started appearing on the radar screen of issues. In late summer, a group from Ann Arbor had secured enough signatures to place a proposal for physicianassisted suicide on the ballot-the infamous Proposal B. Our Board of Directors studies the proposal carefully and, following the direction of the House of Delegates, decided to oppose it. Besides dealing with the media, I was able to work with you, our grassroots members, to educate all physicians and our patients about the complexities of the proposal. In the end, it was resoundingly defeated.

It was a good year for us at the election box. The two Supreme Court justices that we backed won. as well as a goodly number of legislative candidates we worked for and supported.

As the challenges of the elections wound down, new ones appeared. Aware of the implications of its defeat and not wanting to let the defeat of Proposal B be the end of

66 The Michigan State **Medical Society has** little to fear about becoming irrelevant or antiquated because of all the dynamic, caring physicians in this state who are willing to be involved. 99

the issue, your Board has formed a task force to deal with end-of-life issues. It will put forth a strategy to focus the energies of our state society to enable Michigan to be the state experiment in "physicianassisted living," as Oregon is in "physician-assisted suicide." There are 64 new legislators who need to be cognizant of medicine's message in upcoming deliberations, especially around Medicaid issues and tobacco settlement funds. The dynamic tension with Blue Cross persists, as the pressure to hold down health care spending drives many discussions.

While it was certainly these issues and more that shaped this year, it was all of you who made it so special. I shall never forget the courtesies and hospitalities afforded me as I met and talked with you as I traveled the state. The platitudes are worn, but are platitudes because of the kernel of truth in them. The Michigan State Medical Society has little to fear about becoming irrelevant or antiquated because of all the dynamic, caring physicians in this state who are willing to be involved. Time and time again, you stepped up to the plate, in many different arenas, and showed by your actions your commitment to your patients and your profession. I can see talent and energy for many years into the future and I am excited about the possibilities with new people at the lead.

There is a children's book, a classic some would say, which also has appeal to adults, for while it can be read as an adventure of intergalactic travel, it is also an allegory of the human condition. In The Little Prince by Antoine De Saint-Exupery, a small prince from a far off galaxy arrives in the desert where he is befriended by many creatures, including a "grown-up" pilot whose plane has crashed. Slowly, the tales of the little prince's travels and the lessons he has learned through them emerge. But then quite suddenly, he feels he must go back to his planet.

continued on page 61

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Benjamin Disraeli, English statesman

## "People do not change with the times, they change the times."

P.K. Shaw, Author

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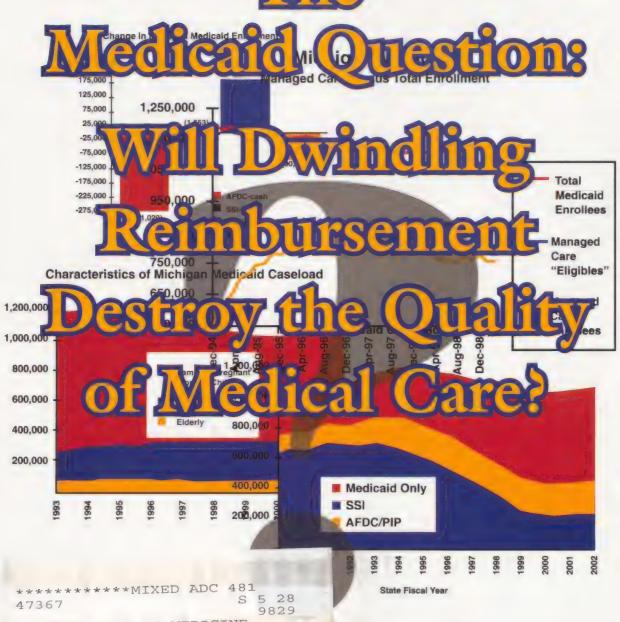
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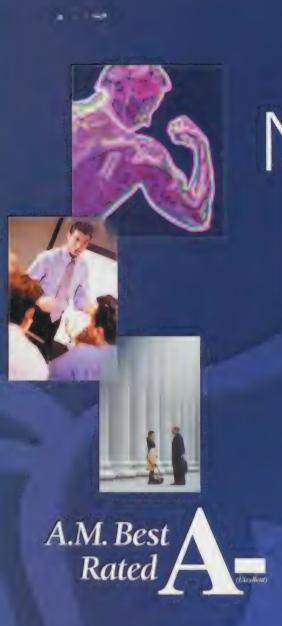


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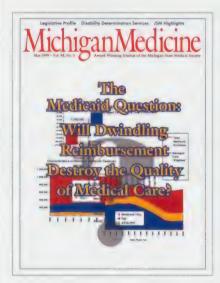
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#### COVER STORY



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#### The Medicaid Question: Will **Dwindling Reimbursement Destroy** the Quality of Medical Care?

The Michigan Medicaid fee schedule has had no substantial revision or cost of living increase since September 1991. Last year, the average physician was reimbursed just 31 cents for each dollar it costs to provide care to a Medicaid patient. Adding to the problem is the fact many health plans don't reimburse in a timely manner.

This situation is causing a moral dilemma for many physicians, forcing them to choose either to reduce patient load or go out of business. The proposed MDCH budget for the year 2000 includes only a 4 percent increase funding to Medicaid Qualified Health Plans, and it is unclear how much of that actually will be allocated for direct patient care.

By Kathleen Farrell

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SPECIAL FEATURE

#### The "New Generation of MSMS" Steers Membership Sections

Despite harsh Michigan weather, nearly 100 physicians turned out for the meeting, which brought together three sections of MSMS membership.

By Stacy Lammers Sellek

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Detroit surgeon received the highest civilian honor bestowed in India for his contributions to the country. By Steve Sternicki

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#### The Need to Work Together: Service Seeks to Streamline Disability Information Retrieval

Patients depend upon their physicians to inform them about the steps they will be required to take toward ensuring disability benefits. In turn, Disability Determination Services depends upon physicians to submit complete and timely records so that they can give the claimant an accurate and prompt decision about a disability claim.

By Holly Spence Sasso

MSR SPOTLIGHT

#### MSMS' Valuable Information Source: Service Reps Provide **Answers, Share Concerns**

Learn how to use this valuable MSMS resource to enhance your practice. By Angela Criswell

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## The "New Generation of MSMS" Steers Membership Sections

By Stacy Lammers Sellek

either snow nor rain nor heat nor gloom of night stays these couriers from the swift completion of their appointed rounds." This unofficial motto of the U.S. Postal Service might as well have been describing the dedication of the MSMS members who attended the 8th annual MSMS Joint Section Meeting (JSM) March 5 – 6, 1999 at the Ritz-Carlton Hotel in Dearborn.

Despite harsh Michigan weather, nearly 100 physicians turned out for the meeting, which brings together three sections of MSMS membership—International Medical Graduates, Young Physicians, and Organized Medical Staff. This year's JSM was patterned on the theme of the "New Generation of MSMS."

"[This year's] JSM is particularly important because of the theme of looking ahead in the medical profession and planning for the new generation as well as the new millennium," said MSMS Speaker of the House of Delegates Dorothy M. Kahkonen, MD.

The sections collectively sent 35 resolutions to the annual House of Delegates

meeting April 30 – May 2 at the Ritz-Carlton for further action. The Young Physician Section approved eight resolutions, which address such issues as rising pharmaceutical costs, and physician unions. The International Medical Graduate section passed 10 resolutions, including requirements of the Education Committee for Medical Graduates (ECFMG) and Medicaid reimbursement

among the topics. Finally, the Organized Medical Staff Section, which celebrated its 15<sup>th</sup> anniversary this year, sent 17 resolutions forward on issues such as Medicaid reimbursement and referrals within HMOs and other MCOs.

New section chairs also were elected at the



(above) MSMS President Cathy O. Blight, MD; Board members and AMA-IMG Delegate AppaRao Mukkamala, MD; AMA-IMG section staff Charles Willis; AMA Delegate Busharat Ahmad, MD; and Board member Hassan Amirikia, MD, meet during a break in the proceedings.

The MSMS International Medical Graduate Section (IMG) governing council takes a break during its final breakout session at the 1999 JSM.



Keynote speaker Edward D. Barlow, a noted Michigan futurist, dares physicians to imagine what they can do to advance their knowledge and their practices in the new millennium.

ISM. They include: OMSS Chair John H. McLaughlin, MD, Birmingham, who succeeds Edward J. Rutkowski, MD, Traverse City; YPS Chair Scot F. Goldberg, MD, Warren, who succeeds David Nadeau, MD, Muskegon; and IMG Chair Bala Srinivasan, MD, Saginaw, who succeeds Amitabha Banerjee, MD, Flint.

Speaking at the JSM luncheon were William G. Plested, MD, of the AMA Board of Trustees, and Edward D. Barlow, Ir., a noted Michigan futurist. Doctor Plested focused on the possibilities and challenges that lie ahead in the medical profession. "Meetings like the [ISM] are essential because we must come together and share ideas among all populations of physicians, especially future physicians," he said.

Barlow dared physicians "to imagine and to be transformed" as he addressed useful resources available to physicians, such as value added services, job growth statistics, demographics, and technological advances. "Are you ready to move

(l to r) David E. Randolph, MD; Tariq Saddiqi, MD; David Nadeau, MD; Fernando C. Gomez, MD; Scot F. Goldberg, MD; Pino D. Colone, MD; and Michael A. Chames, MD.

beyond tomorrow?" he asked. "Now is the time to take command of your future by pursuing the resources that will advance your office staff, and therefore, your practice. Learning about new technologies and research methods will broaden your field of knowledge and prepare you for changes in the medical profession that lie ahead."

Activities such as Family Fun Night and free passes to Greenfield Village and Henry Ford Museum rounded out the meeting fostered the theme of the new generation. Plan now to attend the next annual Joint Section Meeting, set for March 3-4, 2000 at the Ritz-Carlton Hotel, Dearborn.

The author is MSMS Foundation liaison at MSMS.



MSMS Speaker of the House of Delegates Dorothy M. Kahkonen, MD shares a moment of camaraderie with MSMS Board Chair Kenneth H. Musson, MD (left), and MSMS Vice Speaker of the House Paul O. Farr, MD.

#### Physician Disciplinary Process

By Richard D. Weber, JD

MSMS Legal Counsel



Question: A physician friend recently received notification from the State that an investigation has been commenced against him relative to a potential violation of the Public Health Code. Please explain the legal process that takes place relative to allegations against a physician and the rights physicians have in defending themselves.

**Answer:** Contemporaneous with enacting the 1993 Malpractice Reform Legislation, the legislature enacted legislation to revise the discipline process. The legislation became effective April 1, 1994.

**Investigation:** The Department of Commerce, through the Bureau of Occupational and Professional Regulation, is responsible for investigating allegations of misconduct. Information suggesting a violation of the Public Health Code may come from virtually any source, including other physicians, health facilities, state agencies, insurance companies, courts and private individuals. If the Department determines that there is "a reasonable basis to believe the existence of a violation," the Department, with the authorization of the chair of the Board of Medicine, must investigate. In addition, the Department is mandated to "investigate" if information is received that indicates three or more malpractice settlements, awards, or judgments against a licensee in a period of five consecutive years, or one or more malpractice settlements, awards, or judgments against a licensee totaling more than \$200,000 in a period of five consecutive years. Within ninety (90) days after an investigation is initiated, the Department must do one or more of the following: (a) issue a formal complaint, (b) conduct a compliance conference, (c) issue a summary suspension, (d) issue a cease-and-desist order, (e) dismiss the complaint, or (f) file not more than one extension of not more than thirty (30) days. If a complaint is issued, the physician has thirty (30) days from the date of receipt to respond in writing. Failure to respond within the required time frame is deemed to be an admission of the allegations, and the disciplinary subcommittee may impose appropriate sanctions.

Compliance Conference: At any time during the investigation or following the issuance of a complaint, a compliance conference may be scheduled. The conference may include the physician, the physician's attorney, one member of the Department staff and any other individuals approved by the Department. One member of the Board of Medicine also may attend the conference to provide assistance. The purpose of the compliance conference is to attempt to reach agreement. If an agreement is reached, the Department must submit a written statement outlining the terms of the agreement to the appropriate disciplinary subcommittee for approval. If the agreement is rejected by the disciplinary subcommittee, or if no agreement is reached, a hearing before a hearings examiner must be scheduled. The parties are not entitled to make a transcript of the compliance conference and all records of a compliance conference before a complaint is issued are confidential and the conference itself is closed to the public.

Hearing: If no settlement agreement is achieved, the hearings examiner must conduct the hearing within sixty (60) days after the compliance conference. One member of the Board of Medicine who is not a member of the disciplinary subcommittee may attend the hearing and provide assistance. The hearings examiner, who is employed by or under contract with the State, must determine if there are grounds for discipline and prepare recommended findings of fact and conclusions of law for transmittal to the appropriate disciplinary subcommittee. The hearings examiner has no authority to recommend or impose penalties. One continuance may be granted for good cause shown. The physician is typically represented by legal counsel, and the Department is represented by an Assistant Attornev General. The Assistant Attornev General may not be the same individual assigned by the Department of Attorney General to provide legal counsel to the Board of Medicine. Hearings are much like court

Editor's note: If you have legal guestions you would like answered by MSMS legal counsel in this column, jot them down and send them to Kristen Lare, managing editor, P.O. Box 950, East Lansing, MI 48826-0950.

hearings. Witnesses testify and may be cross-examined, and documents are admitted as exhibits. The rules of evidence apply but are not as strictly enforced as in a judicial proceeding.

Disciplinary Subcommittee: Disciplinary subcommittees assume much of the review and sanctioning authority formerly exercised by the Board of Medicine. They are appointed by the chair of the Board of Medicine and are composed of three professional members from the Board of Medicine (the chair excluded) and two public members. Disciplinary subcommittees become involved in the process only after a hearing has been completed. They must meet within sixty (60) days after receipt of the recommendations from the hearings examiner. A disciplinary subcommittee reviews the hearing results to determine whether the hearing established a violation by a preponderance of the evidence (more than fifty percent (50 percent)). If not, the subcommittee may dismiss the complaint. If so, the subcommittee may impose sanctions that include licensure revocation,

probation, fines, and myriad other sanctions. A violation determination must be by a majority vote. A decision on a sanction also requires an affirmative vote by at least one of the public members. The disciplinary subcommittee's determination is final. Although reported to the Board of Medicine, the Board takes no direct role in the sanction. The physician has a right to appeal the subcommittee's decision directly to the Michigan Court of Appeals.

Observations: The current disciplinary process which became effective April 1, 1994 streamlined the system. Although not perfect, it provides due process rights to physicians. It also accelerates the process. The entire proceedings, including the compliance conference, hearing and disciplinary subcommittee action must be completed within one year after the Department initiates an investigation. Unfortunately, there is no statutory sanction if this one year time requirement is not met, and no appellate court has yet decided the issue. 

The author is senior partner with Kerr, Russell, and Weber, Detroit.



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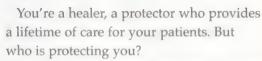
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## Red, Hot, and Blue:

A Review of the Latest R & B CDs

By Roy Goodman, MD

he last few months have seen new CDs from some of my old favorites and some of my new favorites. The Kinsey Report released four CDs from 1988 to 1993, and then they inexplicably stopped. Now they're back with Smoke and Steel. The nucleus of The Kinsey Report are blues legend "Big Daddy" Kinsey's three sons.

Donald is still an excellent singer and a devastating guitarist, but his sound has lost some of its distinctiveness. His guitar used to be unmistakable, with percussive attack and singing sustain; now he sounds more like other blues guitarists ... on some of their best nights. The rest of the sound is vintage Kinseys, with solid drums from Ralph and bass from Kenneth, and with guest artists providing the crisp, prominent second guitar and capable keyboards. The Kinseys were always very uneven songwriters; on Smoke and Steel they don't take as many chances by straying far from

straight blues. And if they don't hit home runs like "Midnight Drive" and "Can't Stop Thinking About You," they don't strike out as often either. It's a good solid release, and I hope they don't wait another five years for the

next one! Long John Hunter is a new favorite whose Border Town Legend and Swinging from the Rafters didn't quite blow me away—they simply charmed me into becoming an instant fan. Hunter has a warm, gruff voice that creates the infectious impression that he's really enjoying himself. His thick, chunky guitar sound is a perfect match for the voice, and the solid backing from his horn-augmented band goes well with his

voice and his guitar. Ride with Me is more of the same, only even better. Hunter's guitar playing is confident and unhurried, and practically every phrase has a logical why-didn't-I-think-ofthat quality shared by few other guitarists. Besides, you have to love this guy—who else would sing (on an earlier release) "I'm a walking catfish?" Hunter's "new" CD is actually a reissue of an older one, but it's much better technically than most reissues—mostly because the "old" recording was done in 1993.

If Ride with Me has a problem, it's lack of variety; Shadow of the Blues, by Little Charlie and the

> Nightcats, shares the problem but also is a very solid collection. The Nightcats-Charlie Baty on guitar, Rick Estrin vocals and harmonica. and a variable supporting cast of bassists and drummershave long been some of the best lyricists in the blues.

humor is mostly dark and biting, backed up by elegant jazz-inflected blues.

New York State of Blues, the new CD from Michael Hill's Blues Mob, is a disappointment compared to Bloodlines and Have Mercy—it's "merely" very good. Hill is still an excellent singer and guitarist, and I may be underrating this CD just because his guitar style is no longer new to me. A few songs are serious clunkers, but others contain more of Hill's clever, literate lyrics. "Up and Down the Stairs" is the story of a man pursuing a fitness program so he can keep up with his girlfriend, and "Young Folks' Blues" is a light-hearted look at the recent crop of highly touted teenage blues stars.

Hill knows about teenage stars because he plays a guest spot on Turn the Heat Up, the debut CD of young phenomenon Shemekia Copeland. Copeland is a zaftig 19-year-old (turned 20 since the release of the CD, I believe) with a big voice, big support from Alligator Records, and a taste for up-tempo, modern blues. Joe Louis Walker appears on an amusing duet, and fellow teenage phenomenon "Monster" Mike Welch sounds very mature on one cut, but Copeland's backing band shines on their own. They're very versatile, and they get welcome help from a talented horn section. Copeland's voice didn't impress me the first few times I heard this CD, but with repeated listening I like it more and more.

I'm still partial to tribute CDs, but I'm afraid I was a sucker to buy Cream of the Crop. Despite a stellar cast of guitarists and superb rhythm support from bassist Tim Bogert and drummer Jeff Martin, practically every cut is a pale reflection of the original. Michael Lee Firkins rearranges "Cat's Squirrel" to good effect, and Eric Gales has a ferocious take on "Sleepy Time Time," but that's about it. The new live tribute to Stevie Ray Vaughan also is a disappointment, with mostly timid, conservative performances from a group of blues legends.

Let's Have Some Fun is a different matter altogether. Fourteen different artists give us their own approaches to Hound Dog Taylor's rip-roaring style, and the results are almost unanimously successful. If you're not a blues fancier, this disc will sound like the episode of "Car 54, Where Are You?" where all the groups in the barber shop quartet competition sang the same song in the same way. If you are a blues fancier, you'll find the selections here "exactly the same but completely different."

The author is a White Lakes otolaryngologist.



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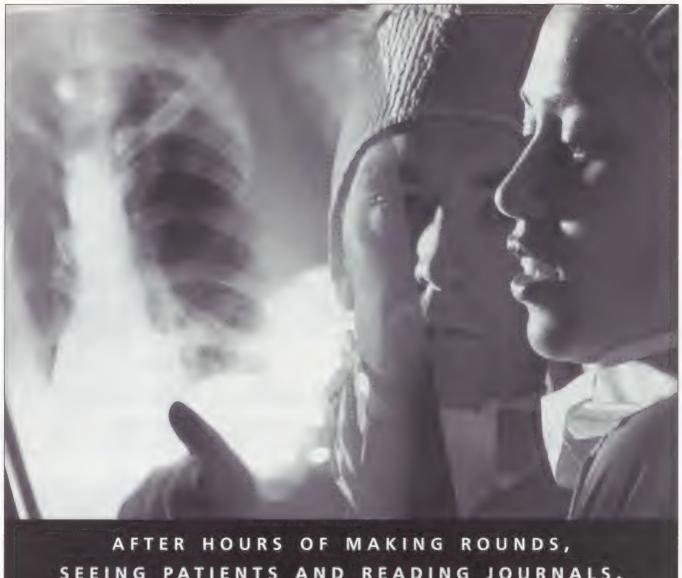


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## Congressman Fred Upton:

An Advocate for Physicians and Patients

By Nate S. Pilon

"Patients must be able to trust that physicians are making medical decisions . . . based solely on their medical needs."

s the debate over managed care reform legislation heats up in Congress, Michigan physicians need a strong voice in Washington who will advocate for access to quality, affordable health care and push for comprehensive, meaningful, patient-protection legislation.

U.S. Rep. Fred Upton (R-6th District) is strongly committed to enacting comprehensive managed care reform legislation that protects and strengthens the physician-patient relationship. Rep. Upton believes that health care should be patient centered, not profit centered. "Rarely a day goes by that I don't hear or read in my constituent mail of serious problems that individuals and families are having with their managed care health plans," Rep. Upton explained. "Physicians are completely frustrated with managed care bureaucracies that get between them and their patients through second-guess health care decisions that put up barriers to medically necessary care."

#### **Protecting Patients' Rights**

One of Congressman Upton's top priorities is to restore and protect the primacy of the physician-patient relationship. As a senior member of the health subcommittee, which has jurisdiction over managed care reform, Rep. Upton co-sponsored the Patient Protection Act, which he hopes will "garner bipartisan support for a bill that will provide strong patient protections and expand access to affordable insurance." As a co-sponsor, Rep. Upton has a greater ability to push for changes that will provide strong patient protection. For example, he shortly will introduce legislation to strengthen the bill's emergency care patient protection language. Rep. Upton also is involved in crafting a strong, timely, internal and independent external appeals process. Under this process, patients would have the right to appeal to independent physicians expert in the area of care under dispute.

#### **Physicians Should Make Medical Decisions**

Rep. Upton believes that physicians must be able to make medical-necessity decisions for their patients, without unrea-

sonable interference from health plans or insurers. "Patients need to be able to trust that their physicians are making medical decisions and recommendations for them based solely on their medical needs," he said.

He feels very strongly that treatment and prevention choices are best made by doctors and their patients, not accountants and executives. "These decisions should be made in the examining room, not the board room," he said. Rep. Upton strongly opposes legislation that focuses medical necessity determination solely on cost. "When the bottom line starts clouding health care choices, something is wrong," he said.

#### **Speaking Out for Physicians**

Representative Upton feels that the frustration and outrage felt by physicians over the antifraud campaign recently launched by the Department of Health and Human Services and the American Association of Retired People (AARP) is justified. He explains that "Overwhelmingly, physicians are dedicated, compassionate professionals who care deeply about their patients and who are intent on practicing the best medicine possible. Physicians have been articulate advocates for their Medicare beneficiaries and have greatly increased my understanding of how the health care policies we craft in Washington affect their ability to give their Medicare and Medicaid patients high-quality health care," he said.

Rep. Upton understands that everyone who cares about the integrity and viability of the Medicare program, including the physician



Rep. Fred Upton

community, wants to stamp out fraud. However, he has seen how this latest, public, high-decibel campaign has smeared everyone with the taint of fraud and abuse. He feels the campaign is "encouraging Medicare beneficiaries to look upon their physicians as potential Medicare rip-off artists and turning them into bounty hunters with promises of rewards for reporting potential fraud and abuse."

Rep. Upton believes all this campaign is doing is seriously undermining the physicianpatient relationship. "If Medicare patients are advised to second guess every aspect of their medical care, what does that say to them about their physician's commitment to them rather than their pocketbook? If I were a physician, I would think twice about taking on any new Medicare patients," he said.

#### **Preventative Health and Education**

Rep. Upton strives to introduce legislation that will educate and protect Americans, ensuring that they lead healthier lives. During the 105th Congress, he introduced the Teen Tobacco Use Prevention Act of 1998 (H.R. 3889). This legislation would prohibit the selling of cigarettes in vending machines where

people under 18 had access, would prohibit the sale of tobacco products to individuals under 18, and would prohibit the distribution of samples of cigarettes.

Rep. Upton also has introduced the Poison Control Center Enhancement and Awareness Act (H.R. 1221). This legislation calls for and would provide assistance to regional poison control centers to establish a nationwide tollfree phone number to access centers. This bill also establishes a national media campaign to educate the public and health care providers about poison prevention and the availability of poison control resources.

Representative Upton serves on the Commerce Committee and its subcommittees: Health and the Environment, Energy and Power, Telecommunications, and Trade and Consumer Protection. He is also a member of the Education and the Workforce Committee and its subcommittees: Post Secondary Education, Training and Life-Long Learning, and Early Childhood, Youth and Families.

He was first elected to the House of Representatives in 1986. He has a voting attendance record of more than 99 percent and did not miss a single vote in 1998. Rep. Upton personally reads and signs every one of the more than 500 legislative letters he responds to each week. He grew up in St. Joseph, Michigan and graduated from the University of Michigan.

Rep. Upton will continue to "support the medical community in its efforts to provide Americans, with the most effective, most appropriate medical solutions to improve the quality of life." Rep. Upton believes in strong legislation that will protect patients' rights and strengthen the physician-patient relationship.

For information about MSMS' federal legislative activities, please contact MSMS managing director Kevin A. Kelly at (517) 336-5742 or kkelly@msms.org.

The author is a communications specialist at MSMS.

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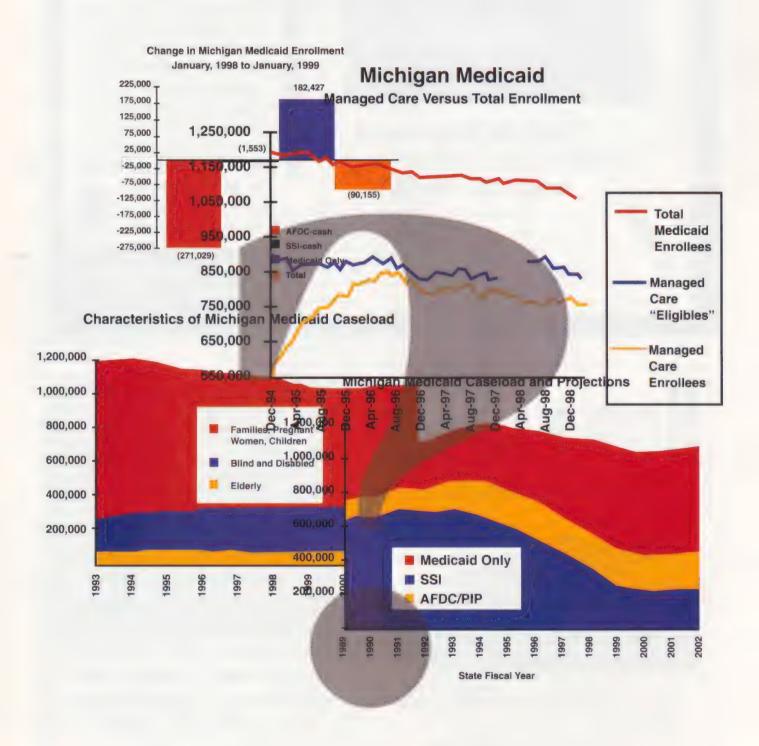


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## The Medicaid Question: Will Dwindling Reimbursement Destroy the Quality of Medical Care? By Kathleen Farrell

octor Daniel Wilhelm's Port Huron pediatric practice has had to absorb approximately \$400,000 each year for the past several years the difference between what it costs to care

"I don't feel the state has recognized its responsibility to care for people on Medicaid in a proper way." -Daniel Wilhelm, MD

for Medicaid patients and what the state reimburses him. It is an issue Doctor Wilhelm and many other Michigan physicians have had to contend with over the years. But now, with the introduction of Governor John Engler's year 1999–2000 budget proposal, Michigan's doctors have reached the breaking point and have decided to take a firm stand against what they say are unreasonable expectations by the state.

"I don't feel the state has recognized its responsibility to care for people on Medicaid in a proper way," says Doctor Wilhelm, a pediatrician at Children's Healthcare in Port Huron. "They apparently expect physicians and hospitals to subsidize the Medicaid program and we've done it for years. But it's reaching a point where physicians cannot afford this any longer." Doctor Wilhelm is not alone in his frustration. Many of his colleagues testified before the State Appropriations Committee in March, and have joined with the Michigan State Medical Society in a massive campaign to raise awareness of this issue.

#### Michigan Ranks 40th in Reimbursement

The Michigan Medicaid fee schedule has had no substantial revision or cost of living increase since September 1991. Last year, the average physician was reimbursed just 31 cents for each dollar it costs to provide care to a Medicaid patient. MSMS statistics show that primary care office overhead costs are approximately 56 to 62 cents per dollar. Adding to the problem is the fact that most physicians don't receive reimbursement in a timely manner—with payments often delayed for more than six months, or not paid at all. Currently, Michigan ranks 40th in the nation for Medicaid reimbursement, which means the state's doctors, who care for Medicaid patients, are paid less than one half of what Blue Cross Blue Shield of Michigan (BCBSM) pays and two-thirds of what Medi-

The issue facing MSMS members concerns

the Medicaid portion of the Governor's year 1999-2000 budget proposal, which shows \$7.8 billion proposed for the Michigan Department of Community Health (MDCH)-including a 4 percent overall increase to Medicaid Qualified Health Plans. It is unclear how much of that will actually reach physicians caring for Medicaid patients, however.

#### Low Increase Affects Patient Access

"We have a lot of angry doctors, not just in my practice but around the state from what I'm hearing," says Doctor Wilhelm. "Many of them are just stating that they're going to withdraw from Medicaid managed care completely." How will this affect the patients? "I think there's going to be a lot of hardship created for these people," he says. "It's an access issue as physicians find that economically they can't provide this care with the dollars the state's given them."

Doctor Wilhelm says it's simply time to put an end to it. "It has me very angry, frustrated, and you just can't seem to get any straight answers from anybody either."

Hampton Mansion, MD, a family practitioner in southeast Detroit, has treated Medicaid patients throughout his 15-year career. "I'm very disappointed in the current situation. We provide health care to people in need at low rates, reduced rates, or unreimbursed rates. That doesn't happen anywhere else in society," says Doctor Mansion. "Everyone pays the same price for a loaf of bread, don't they? No matter how hungry you are. Why is it that physicians are expected to provide the same services at a lower price for certain people? I mean, we do it, but why should we be expected to?"

Like many of his colleagues, Doctor Mansion, who estimates that 25 percent of his practice is under Medicaid, is angry at the situation—even testifying in front of the House Appropriations Committee in March. He says the situation with Medicaid under managed care has reached horrendous proportions. "Physicians are really starting to feel the squeeze on both ends because now we're getting less money and we're expected to provide more services and there's no way we can do both. It was bad enough before, but it's worse now," says Doctor Mansion. "And the administrative burden is just oppressive. We're spending so much more time with paperwork, phone calls, faxes, letters, referrals, authorizations, rescheduling patients—it just takes up so many man hours that it's becoming even more cost prohibitive to provide medical care for Medicaid patients under managed care in the state of Michigan. So, for myself and I'm sure many other doctors, we're starting to look at the fact that we just don't have the extra resources to subsidize the Medicaid system."

#### Small Increase Helps Health Plans, **Not Physicians**

Cecil Jonas, MD, MSMS Board Member and an OB/GYN with practices in Southfield and Detroit and who also serves as chair of the MSMS Task Force on Medicaid Access, says physicians have been unfairly characterized. "MDCH continues to think of physicians who take care of [Medicaid patients] as whining, self-serving people—rather than trying to understand our point of view. Someone who has 50, 60 or 70 percent of Medicaid patients in their practice is in very deep financial trouble." And, Doctor Jonas says, the 4 percent proposed budget increase for Medicaid by the state isn't the answer, because that money goes to the HMOs, not physicians.

"There's no statutory language that says physicians should get an increase," says Doctor Jonas. "The state gives the money to qualified health plans but they don't actually say 'Well let me see how it's being spent.' They're telling us, 'We satisfied our responsibility by giving a 4 percent increase. If you have a problem with how much the HMOs are paying you, go fight them.' " The 3 percent increase was later

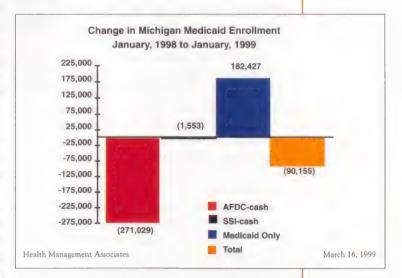
reduced to a 2.2 percent increase in the House Subcommittee on Community Health.

Doctor Mansion says there's an expectation that doctors should simply be quiet and provide the health care anyway. "I would be happy to give away more of my services, if someone would give me more services," he says. "If the phone company said, 'Well doctor, we know you're doing a lot of charity work so we're going to cut your phone bill in half,' or the state of Michigan said, 'We know you're doing a lot of charity work so we're going to cut your income tax in half,' well—if that happens, then I can pass that on to my patients. But that does not happen."

#### **MDCH Responds**

Geralyn Lasher, the MDCH director of communications, will only say, "We're supportive of the budget as it was introduced. The budget called for a 4 percent increase for the qualified health plans and those plans manage about 800,000 folks through the Medicaid Managed "Why is it that physicians are expected to provide the same services at a lower price for certain people? I mean, we do it, but why should we be expected to?"

-Hampton Mansion, MD



Care. We've also got a 3 percent increase for providers for fee-for-service. We were very pleased with the way the budget was introduced

"Mv appropriations people ask me why the health care people always whine. The [Medicaid] budget is basically maxed out."

-James Haverman, director MDCH and that's where the department stands on that."

MDCH Director James Haveman Jr. recently told a crowd at a health care conference that he is tired of hearing health care people complain about money they receive. "Instead of saying thanks or offering a new or better way of doing things they always seem to want more," he said. "My appropriations people ask me why the health care people always whine. The [Medicaid budget is basically maxed out."

Doctor Mansion says physicians have treated Michigan's Medicaid population for years now—even when they know they are losing money doing it. And that's simply not good business. "You know, a business person would have said, 'There's no way I'm going to take patients at a loss.' Well, that's our strength as professionals, but it's our weakness as business people. Physicians have been too nice, and I think it's time we started to get a little bit angry about being pushed around like this. It does translate into decreased quality care for patients, and people need to know that."

#### Managed Care a Hinderance

The managed care aspect has created further problems for everyone involved. In June 1996, MSMS supported the state's initiative to move Medicaid into managed care with the assurance that physicians would be directly involved throughout and also following the transition process. The understanding was that this move would improve both continuity of care and patient access to a stable, user-friendly health care environment. But, most health plans under the new Medicaid Managed Care have reduced actual payments to physicians, while adding new bureaucratic burdens.

Eileen Ellis, a principal with the consulting firm Health Management Associates, says the primary reason for moving Medicaid into managed care was to link patients with a medical home where a physician would serve as

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- Write a letter to the editor of your local paper.
- Write a short essay describing your experience providing care to Medicaid patients, and how inadequate funding will affect your practice. Send your essay to Christine Shearer, MSMS, 120 W. Saginaw, East Lansing, MI 48823; Fax (517) 337-2490; cshearer@msms.org.
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gatekeeper. This was a philosophy already being carried out under MSMS' Physician Sponsor Plan, which created a medical home for Medicaid patients. That plan now is being phased out. According to Ellis, the state's move to managed care "... guarantees them access to services, but also has someone responsible for the management of the services, with a back end goal of obviously saving money."

But, Doctor Wilhelm says, "Since December first when Medicaid managed care became mandatory in our county, we've seen a lower reimbursement rate than before from the HMOs. Certainly more paperwork is demanded and fewer dollars are allotted for patient care than were there before." Doctor Wilhelm adds that the constraints HMOs place on patient referrals also have become increasingly frustrating.

#### **Jumping the Bureaucratic Hurdles**

Dianne Kemp-Foster of Port Huron has experienced it firsthand. A registered nurse and community outreach coordinator for Mercy Hospital in Detroit, Kemp-Foster has an advantage in that she understands the health care industry better than most consumers. But she also has personally felt the stress and frustration that has become synonymous with Medicaid. Her son, Matthew, one of Doctor Wilhelm's patients, was born with multiple congenital anomalies and has lived in a group home for the past five years. He also is autistic. Because he lives in a group home and is covered under Social Security, Matthew was automatically placed on Medicaid even though Kemp-Foster

numerous letters to Matthew's HMO, St. John Health System, asking for variances from the rules so he can stay with the same physicians. "It's been very frustrating because to have Matthew switch doctors at this time is really difficult. It's been about the past year that I've been running against these problems and it's all because of managed care."

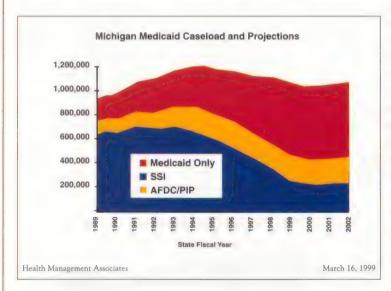
Kemp-Foster says physician referrals through managed care sometimes require an hour drive, even though specialists they've seen for years still are right in town. "The whole managed care system is getting very frustrating and I think that's what a lot of people are feeling. Being a nurse, I'm sure it's easier for me than it is for someone who has no idea about health care. I

> can't imagine anyone doing this who doesn't have a medical background. And it bothers me that a lot of people out there are not getting these kinds of services because they haven't a clue who to write to." Many times, she says, "there doesn't seem to be any rhyme or reason to the rules. One day they say, 'Sure, we'll switch [your doctors],' and the next they say, 'No way, you can't do that.' "

> Kemp-Foster says she would like to see a more humanistic attitude from the health plans. "We should be able to say, 'I want my child to go here or there,' but

I don't see it happening, and that's kind of scary."

Doctors also are concerned that the current Medicaid situation is hindering patient access to care. Oftentimes, Medicaid patients are those most in need of medical attention. And if more and more physicians opt out of participating with Medicaid, those patients will have to find care in the emergency room, which is the most expensive access point, and isn't designed to promote ongoing preventative health care.



and her ex-husband both have their own health insurance coverage. With the move to Medicaid managed care, the family has had to deal with huge bureaucratic hurdles which she says often don't make a lot of sense.

"Matthew's had a lot of long-term physicians that he's been going to since birth. And I have found that since he's been on Medicaid I'm having a hard time keeping his usual physicians," says Kemp-Foster, who has had to write

"When someone is sick or hurting and walks into your office asking for care, you don't ask what kind of insurance they have. You basically just sit down and take care of them."

-John Bizon, MD

"They [physicians] have been taking on more and more of the burden of providing for their patients. It's self sacrifice, and I think it's wonderful and altruistic. But on the business side of it it's very harmful to physicians' practices."

---Hampton Mansion, MD

#### **Untimely Payment**

To participate in Medicaid and to receive federal funds, the state must satisfy 65 federally mandated requirements. Two of these address the state's responsibility to assure that Medicaid recipients have access to quality medical care and to encourage sufficient provider participation through the timely payment of clean claims.

"There are certain standards of care that are expected, especially for children who are on Medicaid," says Doctor Wilhelm. "And in order for the state to receive federal dollars, they have to show that the programs being set up are meeting these standards—immunization rates, number of well-child visits, things of this nature."

The bottom line is that physicians want to treat everyone who needs them—but they also have to run their businesses efficiently. "When someone is sick or hurting and walks into your office asking for care, you don't ask what kind of insurance they have. You basically just sit down and take care of them," says John Bizon, MD, an otolaryngologist in Battle Creek. "In the past we were always able to recoup some of those costs by charging those who have insur-

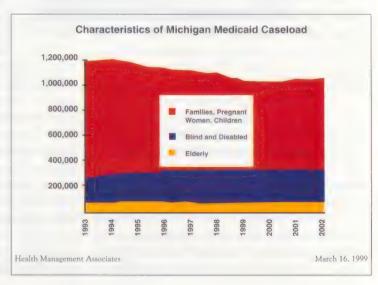
ance a few pennies more. But more recently, managed care has limited the ability of those costs to be shifted from one source to another."

Doctor Bizon says with Medicaid paying physicians only 31 cents on the dollar, overhead expenses aren't even being covered. "It costs more than that to turn on the lights, and to employ the people at our office in order to see our patients."

#### Looking for a Remedy

What needs to be done? According to MSMS, the state's Medicaid system, in any form, must: Ensure and protect patient access to quality health care: promote quality services by enforcing contracts with qualified health plans to guarentee timely payment for medical services; and provide the state with the greatest value for every dollar spent by ensuring that reimbursement adequately covers the cost of providing care. This can be accomplished by increasing funding to the Medicaid system in Michigan to cover physicians' cost of providing services and require timely payment to physician providers from qualified health plans; and also by establishing and maintaining a good faith partnership among physicians, health plans, hospitals, patients and MDCH.

"Within the next year, something is going to have to give," says Doctor Jonas. "A lot of physicians are complaining. A lot of qualified health plans are saying they can't continue to survive. Even with the 4 percent increase, that's very inadequate. Out of a \$7.28 billion budget, to give us 4 percent and to say be happy with that and don't come back, that to me is very, very



#### **MSMS Proposed Changes**

Specifically, MSMS proposes the following recommended amendments to the 1999-2000 MDCH appropriation legislation:

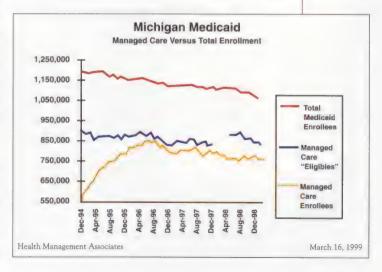
- Qualified health plans are required to pay not less than 90 percent of clean claims from subcontractors for Medicaid covered services within 30 days of receipt and pay not less than 99 percent of clean claims within 90 days of receipt from all in-plan and out-of-plan providers measured on a quarterly basis. Failure to meet these requirements will result in a financial penalty of \$5,000 made payable to the State of Michigan. [\*at time of printing, a similar measure has passed in the State House of Representatives.]
- The proposed capitation rates for qualified health plans under the Medicaid comprehensive health plan shall be submitted to the state insurance bureau for review to determine that the rates are adequate for intended benefit coverage.
- In determining and implementing AIDS Provider Education activities, the Department shall provide funding to the Michigan State Medical Society to continue to serve as lead agency to convene a consortium of health care providers, to design needed educational efforts, to fund other statewide provider groups, and to assure implementation of these efforts, in accordance with the plan approved by the Department. [\*at time of printing, a similar measure has passed in the State House of Representatives.]
- If a qualified heath plan designates nurse practitioners or physician's assistants as primary care providers, the qualified health plan shall provide for appropriate physician supervision of the nurse practitioners and the physician's assistants pursuant to the Public Health Code.

"We want the legislature to ask the right questions of MDCH," adds Doctor Jonas. "They have a responsibility as part of the federal mandate that they should make sure these health plans pay an adequate reimbursement to physicians—at least what it costs us to see a patient. Number two, we want an ongoing oversight by the legislature. We think that's part of the legislative responsibility."

Doctor Jonas says his committee currently is gathering information on the topic and working with MSMS' legal team to see what path to take, including a possible lawsuit against MDCH as a last resort. "That has to be voted on by the MSMS board," says Doctor Jonas, "but that has absolutely not been ruled out. We're not interested in wasting time and money on long, drawn out judicial proceedings. But if we cannot get the attention of everybody else for what we regard as legitimate claims and a very firm unethical situation, then of course we'll have to go the other route."

For Doctor Mansion, there is a misconception about physicians, who for years have continued to provide health care to Medicaid patients at a financial loss to their practices. "Everyone thinks physicians are greedy, but actually, physicians are very giving," says Doctor

"MDCH continues to think of physicians who take care of [Medicaid patients] as whining, selfserving people rather than trying to understand our point of view." -Cecil Jonas, MD. **MSMS** Board Member, chair of MSMS Task Force on **Medicaid Access** 



Mansion. "They have been taking on more and more of the burden of providing for their patients. It's self sacrifice, and I think it's wonderful and altruistic. But on the business side of it it's very harmful to physicians' practices."

Ultimately, he says, it is the state's responsibility to make sure the Medicaid population receives quality medical care, while adequately compensating those who are providing it.

The author is a Okemos-based freelance writer.



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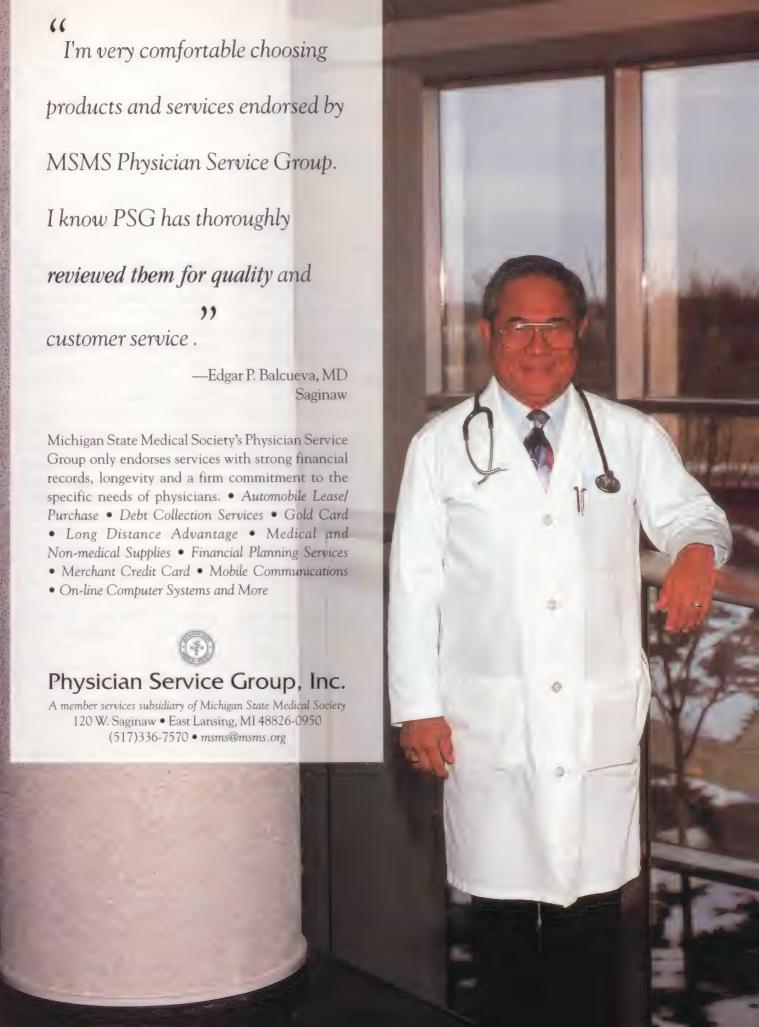
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Judith E. Marr. Executive Director

Phone: 517-337-1351 Fax: 517-337-2490 Email: jmarr@msms.org



## Raj Bothra, MD:

Honored by India for Humanitarian Work

#### By Steve Sternicki

or years, when Raj Bothra, MD, stepped on a plane to go to India, ideas and plans for his latest humanitarian efforts in the country filled his thoughts. As he set out for the destination in March, instead of preparing more ways to give to his native land, this time he was going to receive.

India's President K. R. Narayanan (left) presents Doctor Bothra (right) with Padma Shri.

Two days later, India's president, K. R. Narayanan, presented Bothra with Padma Shri, the highest civilian honor bestowed in India, for his contributions to the country.

Doctor Bothra, a general surgeon at Detroit's Holy Cross Hospital, has spent 6-8 weeks in India each year for the last 15 years, educating people on AIDS, the harms of tobacco and alcohol, and fundraising for hospital medical equipment. But these efforts were not the only factors to play in his earning the award. Doctor Bothra works extensively in the United States for donations to hospitals in India. He also is a key figure in promoting Indo-U.S. relations.

#### The Big Event

Indeed, this visit to India was quite different for Doctor Bothra.

Upon arrival, he traveled directly to the president's house for a meeting. Later, during the award ceremony, attended by high-ranking political officials, the media blitz was on. Television and newspaper crews gathered materials and asked questions. This event is a big one. but especially so this year since Doctor Bothra is the first Indian living outside of India to receive the award. "There was a touch of controversy," he says. "The media was interested in an outsider receiving Padma Shri." He added that a full committee inside and outside of the government chose the awards.

At the ceremony, 15 Padma Shri were given. Nobel Prize winner Amritya Sen was among the recipients of a medal and a Sanad, which Doctor Bothra explained is an honor similar to Knighthood in Britain. During this special moment for him, Doctor Bothra was most happy to have his family there with him. "This is a once in a lifetime thing. It was a very proud moment for all of us, particularly my mother." His mother still lives in India.

#### **Advanced Notice**

In a display of the speedy technological world we live in, Doctor Bothra says he learned of the announcement of his award via the Internet before he received the president's letter in the mail. "That was the most exciting time."

After receiving Padma Shri, Doctor Bothra plans only to increase his work helping India. "This honor opens a lot of doors for me. If I go to the health department regarding an issue. they will be more willing to talk to me. There is a lot of credibility, more visibility. It does help."

He remains modest about his achievements. "Receiving Padma Shri makes me happy because people will be stirred to do more. It will encourage Indians to do more in the country where they have come from."

#### Plans for Future Work

Doctor Bothra wants to continue the same things he's always done, particularly with public health issues. He is increasingly concerned about AIDS in India. "Today the numbers have far exceeded the predictions, for we already have at least six to seven million people with AIDS." A recent major accomplishment was building a new hospital in earthquake-hit Latur. The American Association of Physicians from India garnered more than \$100,000 for the project.

Doctor Bothra is prepared for the long haul in his quest to solve India's problems. "It takes a long time. It's the only way we're gonna win this war. These are very, very big problems in India."

For now, he will continue his frequent plane trips to India. "We love it here, but I feel we have an obligation to do something back there. I will probably increase time there, but I can still raise money and other things from the United States."

The author is a communications intern at MSMS.

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## The Need to Work Together

Service Seeks to Streamline Disability Information Retrieval

By Holly Spence Sasso

Then a patient is diagnosed with a serious illness or physical impairment that will impact life functioning roles, including the ability to work, an important step that physician's must take is to supply detailed records to Michigan Disability Determination Services (DDS).

The DDS is a federally funded state agency that adjudicates disability insurance claims under the Federal Social Security Disability Insurance (SSDI) program.

Patients depend upon their physicians to inform them about the steps they will be required to take toward ensuring disability benefits. In turn, DDS depends upon physicians to submit complete and timely records so that DDS can give the claimant an accurate and prompt decision about a disability claim. Undoubtedly, physicians are very familiar with these demands on their time and interested in streamlining the information dissemination process.

**Advisory Group to Develop Strategies** 

"The guiding principle of the Michigan DDS is to strengthen families whose lives have been affected by disabilities," says Linda Dorn, director, State of Michigan Family Independence Agency Disability Determination Service. "We are committed to balancing the responsibility for timely and accurate decisions with the fiscal responsibility to the general public. We have a tremendous number of cases to evaluate and each decision must weigh on the cost to the SSDI program and to society in general."

In order to assist physicians in facilitating communication between DDS and the medical community, a task force is currently in the process of assembling a Physicians Advisory Council to look more closely at developing strategies to save time and money when responding to the many DDS requests for medical information. According to DDS, the council will also investigate new ways to assure that patients receive timely and accurate decisions when they apply for Social Security Insurance (SSI) disability benefits.

## The Role of the Health Professional

Health professionals play a vital role in the disability determination process and participate in the process in a variety of ways:

- As treating sources or other medical sources who provide medical evidence on behalf of their patients
- As Consultive Examination (CE) sources to perform, for fee, examinations and/or tests that are needed
- As full-time medical or psychological consultants reviewing claims in a DDS, in one of SSA's regional offices, or in SSA central office; or as medical experts who testify at administrative law judge hearings

Michigan DDS processed over 148,000 cases last year with SSI distributing disability benefits totaling nearly \$2 million to Michigan residents alone. According to the Federal Social Security Administration (SSA), which administers DDS programs in every state, nearly two-thirds of disability determinations are made based solely on medical evidence of records received from the claimant's medical sources.

### Specific and Detailed Records Streamline the DDS Process

"When confronted with disability terminology, physicians are often confused and frustrated, particularly when asked to make judgments regarding a patient's functional abilities," according to Sandra Z. Salan, MD, of SSA. "Such reactions are quite understandable be-

Physicians may mail, fax, or call in reports via toll-free telediction.

cause physicians are trained to focus on accurate diagnosis and appropriate treatment, whereas the focus of a disability assessment is the functional evaluation of the patient. Few physicians trained in the United States have received any formal education on disability assessment issues."

"Primary physician's records that are specific and detailed, in terms of functional assessments of what a patient is capable of doing, have a tremendous impact on the quality of the entire program," Dorn said. "Within the 1998 DDS budget of \$61,651,932, medical costs for additional tests, or consultative examinations (CE) resulted medical costs of \$16,714,400. Approximately one-third of disability claims require use of a CE, resulting from a variety of factors, including: inadequate evidence for determination of a disability from a claimants treating source, need for an additional medical opinion, claimant's treating source prefers not to perform an examination, or the treating source does not have the equipment to provide the specific data needed. In the event that additional information is required, DDS prefers to hire the treating source for additional data collection.

#### Medical Evidence of Record

In order to assist physicians in the process of compiling complete, detailed records, it is important to understand the definition of a disability under SSI and how DDS collects and evaluates Medical Evidence of Record (MER). To be considered disabled under the Social Security Act, an individual must be unable "to engage in any substantial gainful activity (work) by reason of any medically determinable physical or mental impairment, which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." Children (applying for SSI benefits) must have an impairment of comparable severity to that which would disable an adult. However, instead of evaluating ability to

work, an assessment is made of how the child's impairment affects his or her ability to perform normal daily activities that healthy children of a similar age can do.

The MER is the most important evidence in the process because it provides a longitudinal picture of the claimants impairment, according to Michigan DDS. Fact sheets and a de-

#### State Disability Determination Service Seeks **Advisory Council Members**

The Michigan Disability Determination Service invites physicians of the Michigan Medical Society to become a part of a new Physician Advisory Council being established to address medical information retrieval issues related to the Social Security and Supplemental Security Income (SSI) disability programs.

The Council will address improved communication between the Michigan DDS and the medical community. In addition, they will discuss strategies to save time and money when responding to DDS requests for medical information, and ways to assure that patients receive a timely and accurate decision when applying for SSI disability benefits.

For information, or to join the task force, contact: Carrie Dunkle, RN, at (800) 383-7155 ext. 62375.

tailed reference guide are available through a variety of DDS Professional Relations staff offices around the state. This information, which includes the Listing of Impairments, which describes, for each major body system, impairments that are considered severe enough to prevent an individual from gainful activity, states the following regarding what constitutes a good MER:

The essential elements of good MER are objective medical findings in the form of reports by the claimants treating physicians/psychologists, hospitals, clinics, the Department of Veterans Affairs, and similar sources of medical treatment. Reports should present symptoms, signs, and laboratory findings that will establish that the claimant has a medically determinable impairment. In most cases, initial medical evidence is all that is needed because evidence provided by the treating source is usually based on a long-term relationship. SSA guidelines emphasize the importance of the treating sources evidence in the decision making pro-

#### **DDS Professional Relations Offices**

Martha Marshall, Lansing (800) 632-3404 Nancy Hammond, Traverse City (800) 632-1097 ext. 738 Sue Rausch, Detroit (800) 366-3404 ext. 30100 Tom Ward, Kalamazoo (800) 829-7763 ext. 73509 Tony Brancaleone (800) 383-7155 ext. 62432

#### Michigan DDS State Office

State of Michigan Family Independence Agency Disability Determination Service Linda Dorn, Director 611 W. Ottawa St. P.O. Box 3001 Lansing, MI 48909 (517) 373-4533 (517) 373-2149 (fax)

#### What Medical Records Should Include

In order for a medical report to furnish the Social Security Administration with sufficient evidence, it should include:

- Medical History
- Clinical findings (such as results of physical or mental status examination)
- Laboratory findings (such as blood pressure, x-rays, etc.)
- Diagnosis (statement of disease or injury) based on its signs and symptoms)
- Treatment prescribed, with response and prognosis
- Medical source statement based on the medical source's own medical findings.

The medical source statement (MSS) should describe the individual's ability to perform workrelated activities, such as standing, sitting, lifting, carrying, walking, handling objects, hearing, speaking, and traveling. In cases of mental impairments, the MSS should present the claimants' capacity for understanding and memory; sustained concentration and persistence; social interaction; and adaptation.

Medical evidence, including clinical and laboratory findings, should be complete and detailed enough to allow DDS to make a determination including the length and limiting effects of the impairment(s), the probable duration, and the claimant's remaining capacity to engage in work-related physical or mental activities. "The more complete the information from the attending physician, the more quickly a claim can be approved," said Doctor Morovitz, who has been with the DDS program for more than 15 years. He began as an internist in the Owosso area and was initially hired by DDS for CEs. Later Doctor Morovitz became a reviewing physician, and he is currently a Quality Assurance Physician for the Michigan DDS program.

"A report stating that 'hand movement is 90 percent limited' is much more informative than a report stating 'limited hand movement,' " he stated. According to Doctor Morovitz, this type of detailed report writing is a good habit to get into. "A good detailed report from a physician is no less a service than treating the patient," Doctor Morovitz said.

There are several ways that physicians can contact the DDS to provide a medical report or chart notes on their patients. Physicians can mail their reports, fax reports or, if they prefer, call reports in toll free by teledication, day or night. Fax numbers and teledictation instructions are included in all requests for medical information.

The author is an Okemos-based freelance writer.

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Dominick Lago, M.D.

Member, American Pain Society Member, American Academy of Pain Management

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#### NEWSMAKERS

Peter Coggan, MD, MSEd, recently was named director of medical education at Henry Ford Health System. Doctor Coggan previously served as associate dean for medical education and associate professor of family and community medicine at the University of Nevada School of Medicine in Reno.

Donald K. Crandall, MD, recently was named vice president of clinical informatics for Mercy Information Systems (MIS), a subsidiary of Mercy Health Services. Prior to joining MIS, Doctor Crandall practiced as a general surgeon with the Muskegon Surgical Associates. He served in the U.S. Navv as a medical officer and also as the first chief of staff of Mercy General Health Partners in Muskegon.

Michael B. Snyder, MD, FACP, recently was named corporate medical director of infection prevention and control at Oakwood Healthcare System. Doctor Snyder previously served at Sinai Hospital as associate chief of the Section of Infectious Diseases and Hospital Epidemiologist.

Peter McCullough, MD, MPH, has been appointed director of the Cardiovascular Diseases Fellowship Training program at Henry Ford Hospital. Doctor McCullough will lead a fellowship of 17 physiciansin-training. He is also collaborating with other health care professionals to analyze which lifestyle and health

factors contribute to cardiovascular disease in the Detroit area.

Edwin Gullekson, MD, vice president of medical affairs at McLaren Regional Medical Center, recently was honored for 30 years of membership in the American Academy of Family Physicians. Doctor Gullekson was recognized during the opening ceremony of organization's 50th Annual Scientific Assembly in Chicago.



Jose Evangelista, MD, recently was elected chief of staff of St. Mary Hospital in Livonia. Doctor Evangelista, a cardiologist, also is certified in internal medicine and nuclear cardiology. He is a fellow of the American College of Cardiology, the American College of Physicians and the Royal College of Physicians and surgeons in Canada.

Eliezer Monge, MD, recently was elected chief of staff-elect of St. Mary Hospital in Livonia. Doctor Monge, an internist, has been on staff at St. Mary since 1968.

Martin Daitch, MD, was elected secretary/treasurer of St. Mary Hospital in Livonia. Doctor Daitch has been an obstetrician/gynecologist at St. Mary for 39 years. He is a fellow of the American College of Obstetricians and Gynecologists and the American College of Surgeons.



Alfred B. Swanson, MD, has been honored by being selected as one of the Outstanding Scientists of the 20th Century. He is awarded a medal and is listed in the annals of "2000 Outstanding Scientists of the 20th Century." A Grand Rapids local orthopaedic and hand surgeon, Doctor Swanson has revolutionized the surgical treatment of the arthritic hand, upper extremity and forefoot since 1962 through his research and development of metal, silicone, and other implants for joint reconstruction.

#### **NEW MEMBERS**

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Peter S. Armstrong, MD, Petoskey Mohammed Ashraf, MD, Flint Andrea Barrack, MD, Flint Wayne Bedell, DO, Midland Gail E. Bowdish, MD, Muskegon George Brodsky, MD, Flint Paul Henry Cho, MD, Dearborn Michael G. Chrissos, MD, Ypsilanti M Jonathan Crooks, MD, Kalamazoo Brian J. Daly, MD, Jackson Maricar O. DeGuzman-Abajero, MD, Flint Alexandra A. DeRiabova, MD, Ann Arbor Mark L. Decco, MD, Eastpointe Sundeep S. Dhillon, MD, Rochester Purushottam Dixit, MD, Detroit Swati Dutta, MD, Ann Arbor Roberto Martin Espinosa, MD, West Branch Ferenc Fabok, MD, Tecumseh Michael Foust, MD, Jackson Jerry Glowniak, MD, Detroit

James Golden, MD, West Bloomfield

John R. Groeneveld, MD, Kingsford

Jit N. Goonewardena, MD,

Bloomfield Hills

Craig T. Hartrick, MD,

Bloomfield Hills Ralph T. Ho, MD, Royal Oak Yuan-Chao Huang, MD, Bloomfield Hills Robert H. Hubers, MD, Whitehall Charles J. Huebner, MD, Harbor Springs Stephen Kirkner, DO, Jackson George A. Krzymowski, MD, Marquette Bela Lang, MD, Iron River Phyllis J. Laswey-Alder, MD, Kalamazoo Mark W. Lay, MD, Kalamazoo Hosn Hanna Maatouk, MD, Flint Bruce H. MacPherson, MD, Bloomfield Hills Pramod Malik, MD, Sturgis Shahzad Manawar, MD, Bay City Donald K. Martin, MD, Ann Arbor Jill M. Mason, MD, Howell Christopher Massin, DO, Detroit Michael S. McDonnell, DO, Jackson Sharon D. Minott, MD, West Bloomfield Jagdish C. Mirchandani, MD, Flint Alberto Miyara, MD, Saline William F. Murray, MD, Novi Michael A. Parish, MD, Fort Gratiot Matthew N. Powell, DO, Muskegon Robert Robinson, MD, Pontiac Merle Rust, MD, Petoskey Michael Schmid, MD, Fenton Mohamed Sfaxi, MD, Southfield Erik E. Sievertsen, MD, North Shores Lonnie D. Simmons, MD, East Lansing Brian R. Smith, MD, Newaygo Wayne A. Smith, MD, Adrian Desanka Stipic, MD, St Clair Shores Van Bao Thai, MD, Flint Brian Tobias, DO, Marquette Joseph Tworek, MD, Jackson

James M. Ulery, MD, Birmingham

Sanjiv Upadhyay, MD, Tecumseh Sotero M. Ureta, MD, Lake City Brett H. Warfield, MD, Detroit Alfred J. Wroblewski, MD, Petoskey Hani Zreik, MD, Saginaw

#### **OBITUARIES**

Julio H. Garcia, MD, died November 8, 1998. He was 64. Doctor Garcia graduated from the medical school at National University in Columbia in 1958. He practiced medicine at hospitals in Alabama, Maryland, and Texas. Doctor Garcia was a member of the American Heart Association, the International Academy of Pathology, the Ameri-Association Neuropathologists, Wayne County Medical Society, and MSMS.

Arnold Kass, MD, died February 2, 1999. He was 87. Doctor Kass graduated from the Detroit College of Medicine in 1936. He served in the army from 1942-47. He was a member of Wayne County Medical Society, and MSMS.

John D. Langston, MD, died January 22, 1999. He was 82. Doctor Langston, a pathologist, graduated from Jefferson Medical College in 1940. He served in the U.S. Navy from 1942-54. He was a clinical associate professor of pathology at Wayne State University. Doctor Langston was a member of the American Society of Clinical Pathologists, the Michigan Pathological Society, the Association of Military Surgeons, and MSMS.

Richard A. Lemmer, MD, died February 15, 1999. He was 80. Doctor Lemmer, a thoracic surgeon, graduated from the John Hopkins medical school in 1944. He was chief of surgery in the Air Force in 1946-48. He was on the board of directors at the YMCA, and was a member of the Kalamazoo Academy of Medicine, and MSMS.

Cleon M. Michael, MD, died in December 1998. He was 74. Doctor Michael, an emergency physician, graduated from Germany's Ruprecht-Karl University in 1964. He was a member of Wayne County Medical Society, and MSMS.

Stephen D. Shawbitz, MD, died January 17, 1999. He was 43. Doctor Shawbitz, a Cass City ophthalmologist, graduated from the University of Michigan Medical School in 1982. He was a member of the American Academy of Ophthalmology, the American Society of Cataract and Retractive Surgeons, Saginaw County Medical Society, and MSMS.

#### DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Consumer and Industry Services, Office of Health Services.

Name: Michael D. Ward, MD, 40000 Grand River #105, Novi, MI 48375

Action, Date Taken: 02-21-99; Summary Suspension Dissolved

Name: Charles M. Asplund, MD, 2437 Hampton Court, SE, Grand Rapids, MI 49546

Action, Date Taken: 02-24-99; Probation—2 yrs.; Fine—\$5,000.00

Reason: Negligence/Incompetence

Name: Marie E. Bem, MD, 2622 Abbott Rd., Midland, MI 48642

Action, Date Taken: 02-16-99; Voluntary Surrender of License; Summary Suspension Dissolved

Dicerise, Junimary Juspension Dissolved

Reason: Technical Violation of the Public Health Code

Name: Zach B. Brown, MD, 14438 W. McNichols, Detroit, MI 48235

Action, Date Taken: 03-25-99; Fine—\$24,000.00; Community Service

Reason: Probation Violation

Name: Paul M. Byrnes, MD, Bixby Medical Center, 901 Kimole Ln., Suite A2, Adrian, MI 49221

Action, Date Taken: 03-01-99; Probation—6 mo.; Reprimand

Reason: Negligence/Incompetence

Name: Peter Palmer, MD, 4806 Rogers Hwy., Britton, MI 49229

Action, Date Taken: 03-26-99; License Suspended—6 mo.; Fine—\$1,000.00

Reason: Failure to Meet Continuing Education Requirements

Name: Daryl T. Parker, MD, PO Box 287, Milan, MI 48160

Action, Date Taken: 02-24-99; Probation—2 yrs.; Reprimand; Fine—\$1,000.00; Final Order dated 12-23-98 is Rescinded.

Reason: Failure to Meet Continuing Education Requirements

Name: Russell C. Thompson, MD, 800 East Columbia, Ste. B, Mason, MI 48854

Action, Date Taken: 02-16-99; Probation—3 yrs.; commencing 6-12-98; Fine—\$500.00

Reason: Mental/Physical Inability to Practice

Name: Kenneth G. Wilhelm MD, 5333 McAuley Dr., Box R7000, Ypsilanti, MI 48197

Action, Date Taken: 03-03-99; Limited License; Probation—concurrent w/limited license

Reason: Violation of General Duty/Negligence

Name: Sharadchandra B. Patel, MD, 4832 Pebworth Place, Saginaw, MI 48603

Action, Date Taken: 03-04-99; License Summarily Suspended

Reason: Criminal Conviction

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#### EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

#### JUNE

1, 8, Bar-Levav Educational Association Ongoing Seminar Series "When intensive psychotherapy has ended: A look at the relationship of ex-patients with their extherapists." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

11-13, Managing Respiratory Diseases. Location: Parc Fifty-Five, San Francisco, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

15, 22, Bar-Levay Educational Association Ongoing Seminar Series "Nervous habits: What they mean and the treatment they require." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

17-19, Issues in Women's Health. Location: Hyatt Regency, Grand Cayman. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11

Category 1 credits.

18-20, Neurology for the Non-Neurologist. Location: Buena Vista Place, Orlando, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

24-26, Clinical Endocrinology for Primary Care Physicians. Location: Sonesta Beach Resort, Bermuda. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

25-27, Coronary Heart Disease Update. Location: Sheraton Fiesta Beach Resort, South Padre Island, TX. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

25-27, Dermatology for the Non-Dermatologist. Location: Hyatt Regency Alicante, Anaheim, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

29 & 7/6, Bar-Levay Educational Association Ongoing Seminar Series "A 'healthy' homosexual lifestyle: Fact or fiction." Location: Town Center, Southfield, MI. Contact: Lester Potempa, DO, Bar-Levay Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075; (248) 353-5333. Approved for: 4 Category 1 credits.

#### JULY

9-11, Coronary Heart Disease Update. Location: Grand Hotel, Mackinac Island, MI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

15-17, Clinical Endocrinology for Primary Care Physicians. Location: Chateau Lake Louise, Lake Louise, Canada. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Issues in Women's Health. Location: Sheraton Hyannis, Cape Cod, MA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Neurology for the Nonneurologist. Location: Sagamore Resort, Lake George, NY. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Endocrinology and Diabetes Update 1999. Location: Boyne Highlands, Harbor Springs, MI. Contact: Joyce Robertson, Registrar, Department of Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: 12 Category 1 credits.

18-24, Mayo Clinic Internal Medicine Certification and Recertification Board Review 1999. Location: Mayo Civic Center, Rochester, MN. Contact: Mayo Foundation, 200 First Street SW, Rochester, MN 55905; (800) 323-2688; or fax (507) 284-0532. Approved for: 56 Category 1 credits.

22-24, Managing Repiratory Diseases. Location: Hvatt Regency, Vancouver, Canada. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-25, Dermatology for the Nondermatologist. Location:

Nemacolin Woodlands Resort & Spa, Farmington, PA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-24, 79th Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, MI. Contact: Paula Parshall, Continuing Medical Education, Munson Medical Center, 1105 Sixth Street, Traverse City, MI 49684-2386; (616) 935-6546; or fax (616) 935-7413. Approved for: 9-12 Category 1 credits.

23-25, Psychopharmacology Update: From Bench to Bedside in Psychiatric Practice. Location: Crystal Mountain, Thompsonville, MI. Contact: Joyce Robertson, Registrar, Department of Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: 12 Category 1 credits.

28-31, Mayo Interventional Cardiology Symposium. Location: Silverado Country Club and Resort, Napa Valley, CA. Contact: Mayo Foundation, 200 First Street SW, Rochester, MN 55905; (800) 323-2688; or fax (507) 284-0532. Approved for: 15 Category 1 credits.

30-31, New Developments in the Management of Breast Cancer and Melanoma. Location: Grand Traverse Resort, Grand Traverse, MI. Contact: Joyce Robertson, Registrar, Department of Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: 6.5 Category 1 credits.

30-8/1, Coronary Heart Disease Update. Location: Tanaya Lodge, Yosemite, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.



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#### **MSMS Meetings** JUNE

- 1, MSMS Medical Business Specialist Program - "Medicare Part B - The Basics." Location: Hampton Inn, Warren, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 3, MSMS Medical Business Specialist Program - "Medicare Part B - The Basics." Location: WMU - Regional Education Center, Warren, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 3, MSMS CME Accreditation Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at 336-5727 (517)or scressman@msms.org.
- 8, MSMS/MICOA Making the Rounds. Location: St. Joseph Hospital, Oakland, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@msms.org.
- 11, MSMS HMO Medical Directors. Location: MSMS Headquarters, East Lansing, MI. Contact: Julie Lester at (517) 336-5768 or ilester@msms.org.
- 15, MSMS Committee on Aging. Location: MSMS Headquarters, East Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 15, Working Toward A Lead Safe Michigan: Regional Conference.

- Location: Saginaw Valley State University, University Center, MI. Contact: Childhood Lead Poisoning Prevention Project at (517) 335-8885.
- 16, MSMS Committee on State Legislation & Regulations. Location: MSMS Headquarters, East Lansing, MI. Contact: Greg Aronin 336-5739 (517)garonin@msms.org.
- 16, MSMS ASM Planning Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Mary Anne Ford at (517) 336-5721 or maford@msms.org.
- 16, MSMS ASM & CME Programming Joint Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at (517) 336-5727 or scressman@msms.org.
- 16, MSMS ASM & CME Programming Joint Reception and Dinner. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman and Mary Anne Ford at (517)336-5727 or scressman@msms.org.
- 22, MSMS Medical Business Specialist Program - "Risk Management for the Office." Location: Troy Marriott, Troy, MI. Contact: Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.
- 24, MSMS Medical Business Specialist Program - "Risk Management for the Office." Location: WMU - Regional Education Cen-

- ter, Grand Rapids, MI. Contact: Iennifer Mogyoros at (517) 336-7581 or imogyoros@msms.org.
- 30, MSMS Committee on Bioethics. Location: MSMS Headquarters, East Lansing, MI. Contact: David K. Fox at (517) 336-5731 or dkfox@msms.org.

#### JULY

- 7, MSMS Risk Management Committee. Location: MSMS Headquarters, East Lansing, MI. Contact: Peggy Galloway at (517) 336-5729 or pgalloway@msms.org.
- 15-18, MSMS Board of Directors Mid-Summer Meeting. Location: Crystal Mountain Resort. Thompsonville, MI. Contact: Irene Frost at (517) 336-5734 or ifrost@msms.org.
- 27, MSMS/MICOA Making the Rounds. Location: Ingham Regional Medical Center, Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.

#### **SEPTEMBER**

- 1, MSMS Committee on Bioethics. Location: MSMS Headquarters, East Lansing, MI. Contact: David K. Fox at (517) 336-5731 or dkfox@msms.org.
- 2, MSMS CME Accreditation Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at (517)336-5727 scressman@msms.org.

- 14, MSMS/MICOA Making the Rounds. Location: Lakeland Hospital, St. Joseph, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 14, MSMS Committee of Hospice Medical Directors. Location: MSMS Headquarters, East Lansing, MI. Contact: Rebecca Blake at 336-5746 (517)rblake@msms.org.
- 15, MSMS CME Programming Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at 336-5727 or scressman@msms.org.
- 15, MSMS Committee on State Legislation & Regulations. Location: MSMS Headquarters, East Lansing, MI. Contact: Greg Aronin 336-5739 (517)or garonin@msms.org.
- 15, MSMS/MICOA Making the Rounds. Location: St. Mary's Hospital, Grand Rapids, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 17, MSMS Joint Physician Executive Organization Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Tom Plasman 324-6958 (517)tplasman@micoa.com.
- 22, Clinical Trends in Pain Management Video Conference Program - Pain Management in Context of End-of-Life Care. Location:

Call for nearest Host Site. Contact: Holly Plunkett, MHA at (517) 323-3443.

- 22, MSMS Group Practice Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Mary Anne Ford at (517) 336-5721 or maford@msms.org.
- 29, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Irene Frost at (517) 336-5734 or ifrost@msms.org.
- 29, MSMS Committee on Aging. Location: MSMS Headquarters. East Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.

#### **OCTOBER**

13, MSMS Risk Management Committee. Location: MSMS Headquarters, East Lansing, MI. Contact: Peggy Galloway at (517) 336-5729 or pgalloway@msms.org.

#### SPECIALTY SOCIETIES JUNE

- 3-5, American College of Cardiology presents the International Symposium on Congenital Heart Disease in the Adult. Location: King Edward Hotel, Toronto, Ontario, Canada. Contact: American College of Cardiology at (800) 253-4636 or fax (301) 897-9745.
- 4, Michigan Society of Respiratory Care Board. Location: MSMS Headquarters, East Lansing, MI.

Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### JULY

21, Michigan Society of Respiratory Care Pulmonary Rehab Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **AUGUST**

6, Michigan Society of Respiratory Care Board Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **OCTOBER**

1, Michigan Society of Respiratory Care Board Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### NOVEMBER

16, Michigan Society of Respiratory Care Pulmonary Rehab Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **AMA MEETINGS** JUNE

20-24, AMA Annual Meeting. Location: Chicago Hilton, Chicago, IL. Contact: Julie Lester at (517) 336-5768.

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Service Reps Provide Answers, Share Concerns

By Angela Criswell

The Member Service Representatives (MSRs) are face-to-face contacts for MSMS physicians and office staff. They keep MSMS leadership informed of the latest issues affecting physicians and the way they practice medicine.

The MSRs interact with physician members and their office staff on a daily basis. If they are not on individual appointments, you may find them at an MSMS educational conference. The



purpose of an MSR is not only to educate physicians on the many ways to utilize their membership, but to be a sounding board for MSMS. In today's changing health care environment, physicians are faced with many challenges—use your MSR to share your concerns.

#### **Medicaid Reimbursement and Timely Payment From HMOs**

The MSRs recently have met with physicians and office managers who have expressed concern regarding the untimely payment of HMO claims. MSRs share this information with Kim Crawford, MSMS chief reimbursement liaison. Crawford documents phone calls and can help to rectify situations with a carrier. She can be reached at (517) 336-5722.

**E & M Coding Seminars** 

The Office of Physician Education and Leadership provides quality physician and office staff programs. In 1998, numerous physicians and office staff requested specialty society-specific conferences. By demand this year

MSMS is conducting both primary care and surgical specialty programs. These conferences are designed to help physicians assist with E&M implementation and simplify the documentation process.

> Currently, the Office of Physician Education and Leadership is offering programs on Physician Practice Mergers, Health Care Negotiation and Conflict Resolution, Building a Compliance Program: Fraud and Abuse, Medical Business Specialists Programs, and MSMS/MICOA Risk Management Closed Claim Reviews. To receive more information on MSMS conferences, please contact Jennifer Mogyoros at (517) 336-7581 or jmogyoros@msms.org.

The author is an MSR at MSMS.

#### For Further Information

If you are interested in scheduling an appointment with your MSR or would like to inquire about MSMS services, please contact the Member Service Representative Department at (517) 336-5749.

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- **Explanation of Serving Sizes**
- 3. Painless Lowfat Options
- 4. Lean Meat in a Heart-Healthy Diet
- 5. Understanding Iron
- Fat. Fiber and Cholesterol
- Fiber Sources and Recommendations 7.
- 8. Healthy Weight Chart
- Healthy Weight Tips
- 10. Keeping Food Safe

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Unfortunately, data is too often used as a club to force compliance rather than to initiate productive discussions of quality improvement.

How can the patient care focus be restored? One emerging trend direct physician contracting with purchasers—shows some promise in this direction. Businesses are seeking direct relationships with physician groups, most notably in Minneapolis. Their rationale is that the front-line person (physician) is closest to the customer (patient) and has the most control over quality and cost.

In direct contracting with employers, physicians will have an opportunity to renew their bond

with patients, with quality patient care as the primary goal and administration the secondary one. With quality improvement, cost efficiency will naturally follow.

Clearly, patients, health providers, and purchasers are frustrated with the current health system. Physicians must rise to the occasion and take the leadership role in offering solutions to health care problems. We must be leaders in the development of quality guidelines and best practices. We must strongly advocate for the proper use of health data to improve quality of care. We must explore opportunities that arise to negotiate contracts directly with employers. We must convince health plans that cost-efficiency follows from quality care. These actions will help us return to a patient-centered health care system.

My point here is not to pretend to have all the solutions to our health care problems. Only to suggest a few. But collectively we can find reasonable solutions. As I serve as president of MSMS this year, I will need your help, your thoughts, and your fresh solutions to old and new challenges facing medicine.

In a nation that has an abundance of talent and resources, let's strive for a health care system that satisfies patients, providers, and purchasers. And lacks nothing.

Doctor Sawhney was installed as MSMS President on May 1, 1999.

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## Physicians, Take Charge!

Krishna K. Sawhney, MD MSMS President



**"I**n all abundance there is lack." —Hippocrates (460-400 B.C)

Despite the \$1 trillion spent annually on health care in the United States, the system is still sadly lacking.

The wise words spoken by Hippocrates 2,400 years ago, ironically, apply to our health care system today. In our abundance of resources, there is a serious lack of satisfaction with the health care system.

But why? After all, medical care in the United States is the very best in the world. Why are patients, physicians, and purchasers wringing their hands and holding their heads? As president of the Michigan State Medical Society, I hear it from all sides, which is clearly an indication of a need for change.

Patients are fed up. They want to be able to choose their physician, develop a trusting and long-term relationship, and to have a health plan to fully cover them in event of catastrophic need. We have all experienced or heard of cases in which an insurer acts callously in denying coverage of appropriate care. I can think of two examples.

One woman had breast cancer and her physician recommended a stem cell transplant, which was denied by the insurer. It was only through significant time, effort, and legal involvement that the procedure was eventually covered. The whole affair was devastating to the patient and family.

The other case is tragic. The wife of my car leasing agent recently had

surgery to remove a benign brain tumor. After the surgery, her prognosis was for a full and complete recovery. Unfortunately, a few days after the surgery, she fell into a coma and required skilled nursing care. The health plan denied coverage for the care-stating that it wasn't included in the plan contract—even after she came out of the coma and clearly required rehabilitative care. Along with his overwhelming anxi-

66 In a nation that has an abundance of talent and resources. let's strive for a health care system that satisfies patients. providers, and purchasers. And lacks nothing. 99

ety and concern for his wife and family, my friend also is faced with horrendous out-of-pocket medical costs of \$15,000 monthly. A system that allows such blind-siding of patients with "full" health care coverage is desperately in need of change. Start with the language of health plans, which is overly complicated and laden with legalese.

Where has the system gone wrong? As I see it, one major problem is that the patient has been nudged out of the center of the

health care system and replaced by the health plan itself. The patientcentered approach has been usurped by the business-centered approach in the name of cost-containment. This is why unreasonable, callous coverage decisions get made. Coverage decisions are increasingly based on financial soundness rather than medical judgment.

Medical judgment is too often ignored or substituted with formulaic business thinking. I can think of two areas in which health plans have reduced useful patient care tools to perfunctory business processes.

The first is the development of quality guidelines and "best practices." Quality guidelines should be developed by physicians with local input, not unilaterally by insurance companies. Proper guidelines have been shown to improve quality and reduce cost—the stated goal of purchasers. Some examples of guidelines developed by physicians that have successfully reduced costs involve treatment of patients with asthma, diabetes, and congestive heart failure. Protocols developed by anesthesiologists over the past decade are another significant success.

The second area is the use of health care data. Health plan data tends to be used against physicians rather than for their education. Inevitably, health plans focus on financial implications of data rather than patient care improvement. With the proper supporting evidence, physicians are willing to change their practice methods.

continued on b. 55

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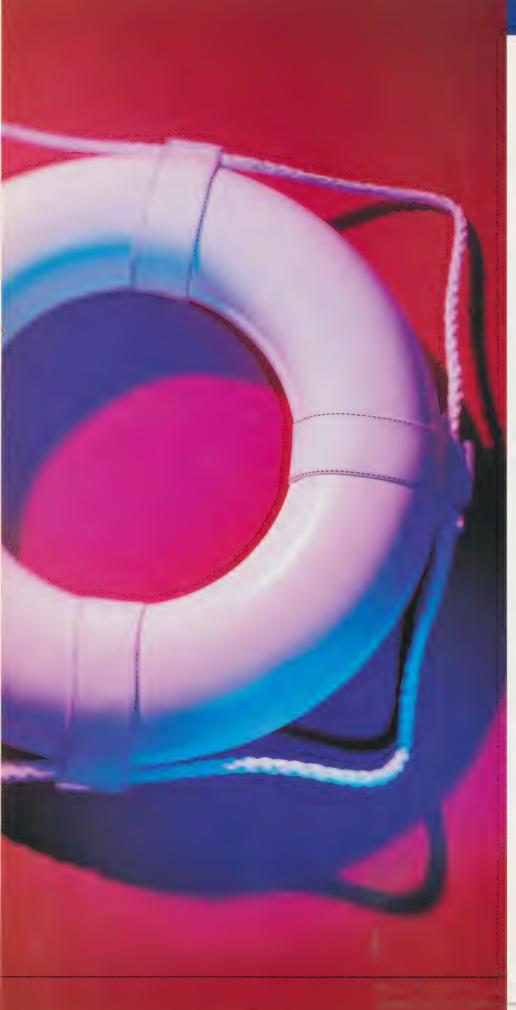


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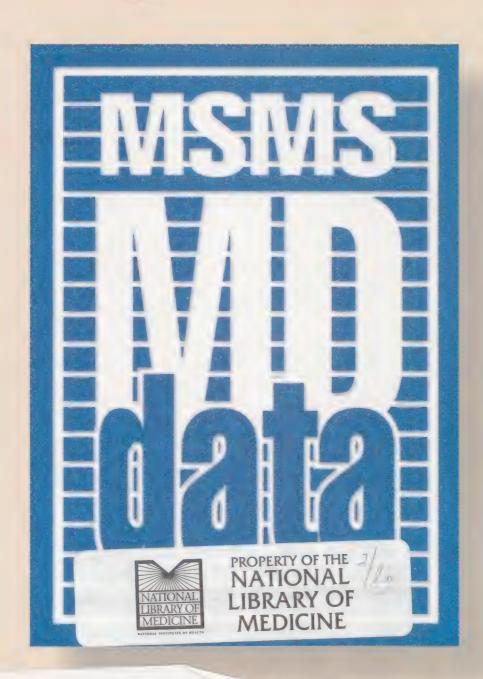
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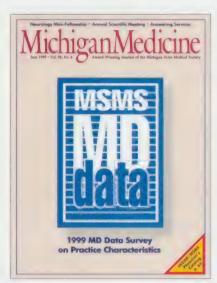
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#### COVER STORY



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#### 1999 MD Data Survey on Practice Characteristics

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MSMS has conducted its 4th biennial MD Data Survey on Practice Characteristics. The survey results allow us to analyze the data from 1999. We then compare it to that data collected by the three prior surveys, starting with 1992. While the information allows individual physicians to compare their practice to others, the data also is arranged in order to display trend analyses. Information in this form supplies physicians with valuable facts that can be used in the management of their practice.

By Laura K. Campbell

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**EDUCATIONAL UPDATE** 

#### MSMS on Cutting Edge of Education: 134th Annual Scientific Meeting Brings Physicians into the New Millennium

This year's Annual Scientific Meeting will focus on innovation in modern medicine. ASM attendees will learn about cutting-edge developments in each of the specialties.

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#### One of MSU's Best-Kept Secrets: Free CME Boosts Knowledge of Neurology 14

MSU-designed neurology mini-fellowship combines clinical training and academic work to teach primary care physicians about the latest neurological procedure, diagnosis, and treatment.

By Gregory Brusstar

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By Gregory Brusstar

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MSMS and the MSMS Alliance, along with MICOA and Stratton, Cheeseman, & Walsh, would like to recognize physicians who volunteer their time in their communities. By Peter A. Duhamel, MD

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## MSMS on Cutting Edge of Education

134th Annual Scientific Meeting Brings Physicians into the New Millennium

By Ahmad Abdul-Quadir

"ASM attendees will learn about cutting-edge developments in each of the

specialties."

---Evangeline J. Spindler, MD, ASM **Planning Committee** co-chair

orld-renowned speakers and cuttingedge developments will make the 134th Annual Scientific Meeting, held at the Ritz-Carlton in Dearborn, an event to remem-

For the first time in its long history, the Annual Scientific Meeting (ASM) is being held concurrently with the annual William Beaumont Lecture. The keynote speaker is surgeon Denton A. Cooley, MD, known for performing the first successful human heart transplant in the United States (1968). In 1969, he became the first heart surgeon to implant an artificial heart in man. To date, Doctor Cooley and his medical team have performed more than 91,000 open heart operations—more than any other group in the world.

A prevailing theme of this year's ASM is pain management. Three distinct courses will be offered (one each day). According to ASM Planning Committee member Mary Elizabeth Roth, MD, "The ASM committee keeps

a close watch on legislative issues to make the appropriate courses available at the ASM."

#### Planning for the Future

The ASM Planning Committee has gone to great lengths to present an informative series of lectures and discussions, interesting vendors, and one of the best networking opportunities of the year. ASM Planning Committee Chair, Kamran S. Moghissi, MD, said "We try to develop a balanced program that's on the cutting edge of medical education and technology. . . . [This] year, we plan to bring even more outstanding speakers from around the state and the nation to discuss the most current and important advances in medicine."

This year's ASM will focus on innovation in modern medicine. ASM Planning Committee Co-Chair, Evangeline J. Spindler, MD, stated, "ASM attendees will learn about cutting-edge developments in each of the specialties." Physician-assisted living, infectious diseases, and menopause management are just a few of the contemporary medical issues that will be fea-

#### Back to the Classroom

A new course in risk management, "Overcoming Stress and Burnout," focuses on the emotional and psychological well being of physicians in relation to avoiding potentially risky situations. Physician attendees will learn about the importance of taking care of themselves and maintaining supportive environments at home. The most significant component of that support system, physicians' spouses, also will be active at the ASM. The MSMS Alliance,



Link to Technology—physicians participating in a hands on introductory course to computers and the Internet at the 1998 Annual Scientific Meeting



Provocative Discussion—Physicians listen intently to a seminar at the 1998 ASM.

presents "The Female Abuser," examining the little-mentioned abuse that women inflict on others, like children, elderly parents, as well as mental health, and other patients.

#### **Quality Programming**

The ASM planning committee has managed to offer quality presentations without sacrificing quantity, providing a variety of topics for attendees. Doctor Moghissi said, "Attendees will find many different courses encompassing a large range of medical specialties. In addition, there are plenary sessions offered by expert speakers from universities and health institutions from around the state that are geared toward the private family practice physician."

"Often times, primary care doctors might refer dozens of patients to a specialist that they have never even had the chance to meet," added Doctor Roth. "The ASM provides primary-care physicians with the chance to network with specialists and to share meaningful, professional experiences with one another," she said.

The 134th Annual Scientific Meeting will be held November 3-5, 1999 at the Ritz-Carlton Hotel in Dearborn. For registration, patron, or special event information, please contact Brenda Menzies (517) 336-7580 or bmenzies@msms.org.

The author is a communications specialist at

"This year, we plan to bring even more outstanding speakers from around the state and the nation to discuss the most current and important advances in medicine."

---Kamran S. Moghissi, MD, ASM **Planning** Committee chair

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### Hearing Impaired Patients

Legal Obligation to Treat and Pay for Interpreters

> By Richard D. Weber, JD MSMS Legal Counsel



**Question:** Recently I was contacted by a deaf individual who requested to become my patient. Am I obligated under the law to treat this individual? Am I required to pay for the services of an interpreter to communicate with this patient?

Answer: The Americans with Disabilities Act of 1990 (ADA) is a comprehensive federal statute intended to eliminate discrimination against persons with disabilities. The ADA prohibits discrimination not only by employers but by places of public accommodation as well. Medical offices are public accommodations subject to the ADA.

As a public accommodation, a medical office must ensure that no individual with a disability will be excluded or denied its services because of the disability or because of the absence of auxiliary aids or services necessary to effectively communicate with the individual. Therefore, a physician is prohibited by the ADA from refusing to treat a patient solely because of the individual's deafness or because the physician refuses to provide an auxiliary aid or service. If the physician is not taking any new patients, it is not a violation of the ADA for the physician to refuse a new deaf patient. A physician is not affirmatively obligated to treat a patient simply because of the disability. However, refusal to treat a deaf patient on the basis of the disability is a violation of the ADA.

Individuals with disabilities such as vision, hearing or speech impairments, which substantially limit their ability to communicate are entitled under the ADA to auxiliary aids or services, which must be provided by a public accommodation. In the case of a deaf patient, an effective auxiliary aid is not confined to interpreter services. This requirement is a very flexible one. An appropriate auxiliary aid is any means or device that leads to effective communication under the circumstances. An interpreter may not be needed at all. The ADA lists numerous examples of auxiliary aids including note takers, computeraided transcription services, assistive-listening devices, telephone handset amplifiers, and written materials.

Whether a particular auxiliary aid will lead to effective communication depends on the particular circumstances. In a routine visit, exchanging written notes with the patient may be very effective. Use of a family member who can interpret through sign language also may be possible. In a more complex visit involving extensive treatment, the services of a professional interpreter could be required. In such an instance, the physician is obligated by the ADA to pay for such services.

There are two situations where a physician would be excused from providing auxiliary aids or services. The first occurs when the provision of such services would create an undue burden. This involves a balancing test, analyzing factors such as the expense of the aid or service against the size of the medical practice and its resources. The requirement to provide auxiliary aids or services also is eliminated if the physician can demonstrate that taking such steps would fundamentally alter the nature of the services being provided.

Providing an interpreter for every visit by a deaf patient might well prove to be an undue burden for a medical practice, thus excusing the public accommodation from providing this type of aid or service. However, in the majority of instances, effective communication can probably be achieved through means other than a professional interpreter service.

The author is senior partner with Kerr, Russell, and Weber, Detroit, USA

Editor's note: If you have legal guestions you would like answered by MSMS legal counsel in this column, jot them down and send them to Kristen Lare, managing editor, P.O. Box 950, East Lansing, MI 48826-0950.



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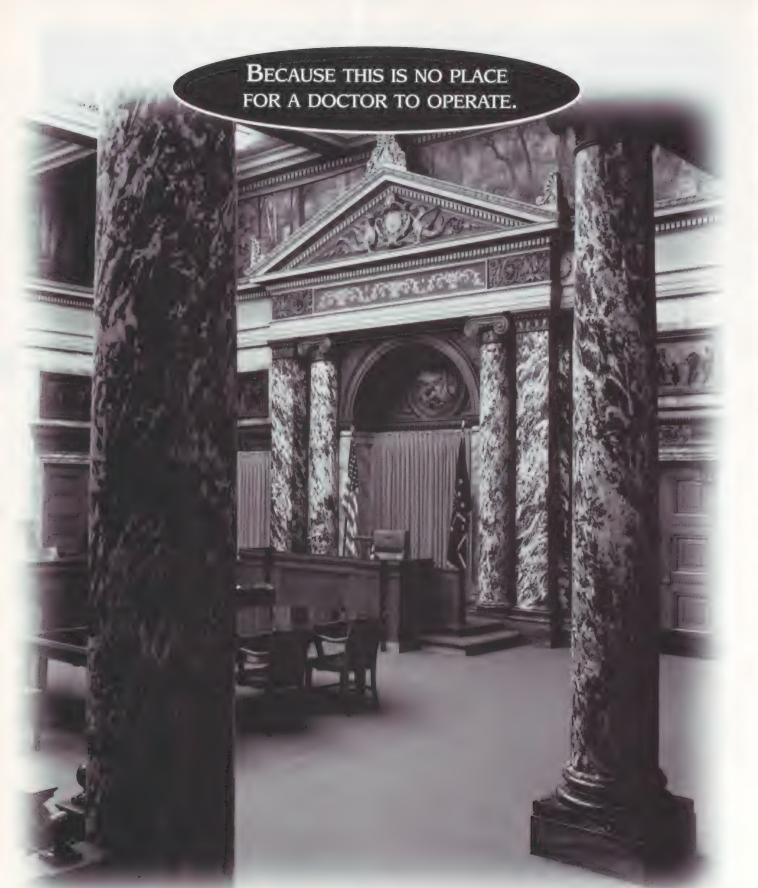
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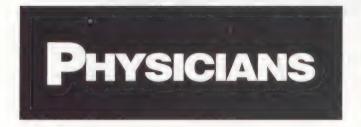


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## One of MSU's Best-Kept Secrets

Free CME Boosts Knowledge of Neurology

By Gregory Brusstar

arkinson's disease expert Glen Ackerman, MD, is excited about the advances in neurology in the past decade. And he wants physicians in practice to know more about them.

He and six other Michigan State Universityaffiliated physicians have put together a unique two-day program in neurology for primary care physicians.

The program, a "mini-fellowship," is a combination of clinical training and academic work. It's intensive and physicians pack a lot into two days.

An Active Approach to CME

"This is a new way of delivering CME training," Doctor Ackerman said. "It's effective, rewarding, and active learning."

The practical program is designed for primary physicians in practice. "It's stimulating and we have good conversations and interchanges," Doctor Ackerman says. "Sometimes I think the faculty learns as much as the participants."

The mini-fellowship is highly relevant for primary care physicians, says Doctor Ackerman, because advances have made many more neurological disorders treatable.

The program includes two nights at MSU's Kellogg Center and grants 16 CME credits. It's also free of charge, making it one of MSU's best kept secrets.

#### Learn the Latest in Neurology **Treatment**

"The 1990s was a great decade for neurology," says Doctor Ackerman, who is director of the Michigan State University Clinical Center's Parkinsons Disease Clinic. "Fifteen years ago, there wasn't any way to treat many neurological disorders. In the past decade, many drugs and procedures have been developed so that

now we can talk about treatment options. Some of the progress in diagnosis and treatment in the field of neurology is the use of TPA in stroke, new medications for Parkinson's disease, and the immunomodulating therapies for

multiple sclerosis."

The mini-fellowship offers rotations in Parkinson's disease, geriatric neurology, neurophthalmology, headache, neuroradiology, general adult neurology, and multiple sclerosis.

The faculty for the mini-fellowship are professors in MSU's Center for Clinical Neuroscience and Ophthalmology:

Glen Ackerman, MD, director of the Neurology Mini-fellowship and director of the Parkinson's Disease Clinic at the Center.

Eric Eggenberger, DO, assistant professor of Neurology and co-director for the Center.

David Kaufman, DO, professor of Neurology and director of the Center.

Edmund Messina, MD, associate clinical professor and director of the Michigan Headache Treatment Network.

Daniel Murman, MD, assistant professor of Neurology and director of the Geriatric Neurology and Memory Disorders Clinic at the Center.

Joseph Pysh, DO, PhD, professor of Neurology and general neurologist at the Center for Clinical Neuroscience and Ophthalmology.

George Ristow, DO, professor of Neurology and director of the Muscular Distrophy Clinic at the Center.

The program includes two nights at MSU's Kellogg Center and grants 16 CME credits. It's also free of charge, making it one of MSU's best kept secrets.

**Highly Recommended** 

One participant, Howard Mahabeer, MD, who practices in Reed City said the program was excellent. "I would definitely recommend the program to physicians in practice," said Doctor Mahabeer, who specializes in internal medicine and pediatrics. "It's important information to know because we can now treat some of these problems, whereas before all we could do was diagnose them." He said he is seeing more patients with neurological disorders. The rotation on multiple sclerosis was particularly relevant to his practice.

Another physician, Susan Courtnage, MD, an internist from Eaton Rapids highly recommends the program. "I found it useful to follow the neurologists through the diagnosis, monitoring, and treatment of patients," she said. "I was especially interested in Parkinson's and multiple sclerosis since those are disorders I don't see often in my practice." Doctor Courtnage also found the neuroradiology rotation, which involved CAT and MRI scan interpretation, to be informative. After 21 years in practice, Doctor Courtnage said she's seeing more neurological disorders as her patients age.

Doctor Ackerman got the idea for the minifellowship after attending a similarly structured program in North Carolina. "It's a more active learning process and I believe it works," he said.

Participants select three half-day rotations, with a half day of academic work. Physicians work one-on-one and in small groups.

This program has been made possible through unrestricted educational grants from DuPont Pharmaceuticals, Roche Pharmaceuticals, Athena Neurosciences, and with the active cooperation of the Michigan Parkinson's Foundation.

The Neurology Mini-fellowship has been approved for 16 hours of Category 1 CME credit through Michigan State University.

Hands-on Training

In the Parkinson's disease rotation, physicians see newly diagnosed patients and discuss diagnosis and treatment options. In geriatric neurology section, participants work with Doctor Murman on Alzheimer's disease and neurology issues for older patients. The Headache rotation is conducted by Doctor Messina, director of the Michigan Headache Treatment Network. Neuroradiology training consists of interpreting magnetic resonance imaging (MRI) scans. General adult neurology covers headache, Parkinson's, multiple sclerosis, tremors, and Alzheimer's disease. The multiple sclerosis rotation includes a discussion of new drug treatments, new ways to make diagnoses, the physical examination procedure, and MRI scan interpretation.

Openings are available in the programs on October 21-22, November 11-12, and December 9-10. Request a mini-fellowship application by calling (517) 371-3307, by fax (517) 371-5868, or GlenAckerm@aol.com. ■

The author is an Okemos-based freelance writer.

"I found it useful to follow the neurologists through the diagnosis, monitoring, and treatment of patients."

-Susan Courtnage, MD

For a complete calendar of upcoming MSMS educational events and opportunities, see p. 16 or visit the newly updated MSMS Web site at www.msms.org.

#### EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

#### JULY

9-11, Coronary Heart Disease Update. Location: Grand Hotel, Mackinac Island, MI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500. Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

15-17, Clinical Endocrinology for Primary Care Physicians. Location: Chateau Lake Louise, Lake Louise, Canada, Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Issues in Women's Health. Location: Sheraton Hyannis, Cape Cod, MA. Contact: Linda Main. Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Neurology for the Nonneurologist. Location: Sagamore Resort, Lake George, NY. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

16-18, Endocrinology and Diabetes Update 1999. Location: Boyne Highlands, Harbor Springs, MI. Contact: Joyce Robertson, Registrar, Department of Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: 12 Category 1 credits.

18-24, Mayo Clinic Internal Medicine Certification and Recertification Board Review 1999, Location: Mayo Civic Center, Rochester, MN. Contact: Mayo Foundation, 200 First Street SW, Rochester, MN 55905; (800) 323-2688; or fax (507) 284-0532. Approved for: 56 Category 1 credits.

22-24, Managing Repiratory Diseases. Location: Hyatt Regency, Vancouver, Canada. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-25, Dermatology for the Non-dermatologist. Location: Nemacolin Woodlands Resort & Spa, Farmington, PA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

23-24, 79th Annual Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City, MI. Contact: Paula Parshall, Continuing Medical Education, Munson Medical Center. 1105 Sixth Street, Traverse City, MI 49684-2386; (616) 935-6546; or fax (616) 935-7413. Approved for: 9-12 Category 1 credits.

23-25, Psychopharmacology Update: From Bench to Bedside in Psychiatric Practice. Location: Crystal Mountain, Thompsonville, MI. Contact: Joyce Robertson, Registrar, Department of Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: 12 Category 1 credits.

25-28, 26th Annual Michigan **Emergency Medicine Scientific** Assembly. Location: Grand Hotel. Mackinac Island, MI. Contact: Diane Bollman, MCEP at (517) 645-8050 Approved for: Maximum of 17 Category 1 credits.

28-31, Mayo Interventional Cardiology Symposium. Location: Silverado Country Club and Resort, Napa Valley, CA. Contact: Mayo Foundation, 200 First Street SW, Rochester, MN 55905; (800) 323-2688; or fax (507) 284-0532. Approved for: 15 Category 1 credits.

30-31, New Developments in the Management of Breast Cancer and Melanoma. Location: Grand Traverse Resort, Grand Traverse,

MI. Contact: Joyce Robertson, Registrar, Department of Medical Education, P.O. Box 1157, Ann Arbor, MI 48106-1157; (734) 763-1400 or (800) 800-0666; or fax (734) 936-1641. Approved for: 6.5 Category 1 credits.

30-8/1, Coronary Heart Disease Update. Location: Tanaya Lodge, Yosemite, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

30-8/1, Neurology for the Non-Neurologist. Location: Eldorado Hotel, Santa Fe, NM. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

#### **AUGUST**

6-8, Issues in Women's Health. Location: Buena Vista Palace, Orlando, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

6-8, Managing Respiratory Diseases. Location: Hyatt Regency, Monterey, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

12-14, Dermatology for the Non-Dermatologist. Location: Chateau Lake Louise, Lake Louise, Canada. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

13-15, Clinical Endocrinology for Primary Care Physicians. Location: Snow King Resort, Jackson Hole, WY. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO 80120-4569; (800) 421-3756; or fax (303) 798-5731. Approved for: 11 Category 1 credits.

15-20, Mayo Clinic Review of Women's Health Care. Location: Honolulu, HI. Contact: Mayo Foundation, 200 First Street SW, Rochester, MN 55905; (800) 323-2688; or fax (507) 284-0532. Approved for: 25 Category 1 credits.

26-29, ACC / ACA&I Board Review Program in Interventional Cardiology. Location: Hyatt Regency, San Francisco, CA. Contact: American College of Cardiology, ATTN: EP, P.O. Box 79231, Baltimore, MD 21279-0231; (800) 2534636 ext. 695. Approved for: 21 Category 1 credits.

#### **SEPTEMBER**

10-11. The Second Dearborn Summit: Reducing Costs and Improving Performance in Cardiovascular Care - Practical Lessons. Location: Dearborn Inn. Dearborn. MI. Contact: Registration Secretary, Extramural Programs Dept., American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20814-1699; (800) 253-4636 ext. 695; or fax (301) 897-9745. Approved for: 9.5 Category 1 credits.



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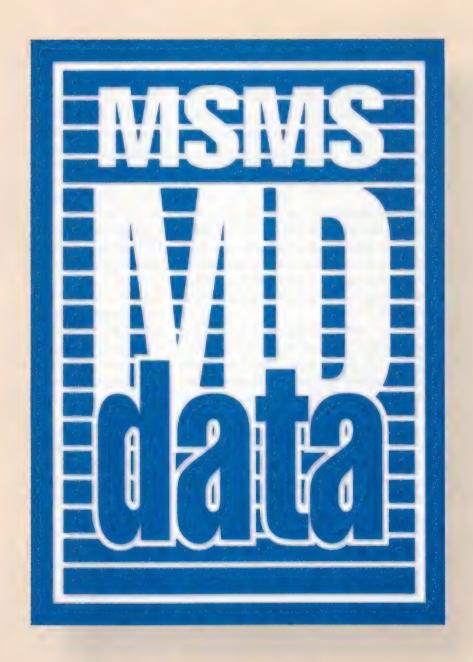
William F. Siewertsen, Partner 1094 Nautical Drive Suite 600 Okemos, MI 48864 Ph (517) 347 7343 Fax (517) 347 1718

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## **Special Report**



1999 MD Data Survey on Practice Characteristics

## 1999 MD Data Survey on Practice Characteristics

By Laura K. Campbell

s we stand on the brink of the 21st century, it's time to take a look back at how the practice of medicine has been affected by the various changes to health care and attempt to make some predictions for the new millennium.

Michigan physicians are facing new challenges with each new year. In order to address those challenges, physicians must possess individual creativity, allowing them to appropriate their limited time and resources effectively. Physicians are learning to look to the past in order to plan for the future.

With this in mind, MSMS has conducted its 4th biennial MD Data Survey on Practice Characteristics. The survey results allow us to take the data from 1999 and analyze it and compare it to that data collected by the three prior surveys, first published in 1993. While the information allows individual physicians to compare their practice to others, the data also is arranged in order to display trend analyses. Information in this form supplies physicians with valuable facts that could be used for the management of their practice. Along with the trend analyses, we also are able to capture and exhibit those smaller changes that are beginning to emerge. An example of this would be in the case of how Michigan physicians have dramatically changed the methods by which they are contracting with health plans, just within the past two years.

The survey was mailed to all actively practicing members in November 1998, and a statistically significant response was again achieved.

The results of this comprehensive survey will be used throughout the year in several ways to promote the interests of all physicians and patients, beginning with its debut in this edition of Michigan Medicine. MSMS will use the data for various program design and modification. It

will also be used in legislative testimony, press releases and public information campaigns. A slide presentation highlighting the findings of the survey is available to interested groups. Individual physicians are encouraged to use the information in local discussions with consumers, employers

and other health care providers.

Following are some of the key findings of the 1999 MSMS MD Data Survey on Practice Characteristics:

#### **DEMOGRAPHICS**

- The survey sample was 86.2 percent male and 13.8 percent female.
- •Nearly half were from the Detroit/Ann Arbor metropolitan area.
- The average respondent was 50 years old and had been in practice for 19 years.
- Two-thirds of physicians responding were specialists; in urban areas, 71 percent of physicians were specialists, whereas in rural areas, 51 percent were.
- •Of the physicians who responded, 36 percent went to medical school in Michigan.

#### PRACTICE ARRANGEMENT

- The proportion of physicians in solo practice remained stable at 36 percent in 1999. The percentage of employed physicians and group practice physicians also remained relatively stable, fluctuating by only 1 or 2 percent.
- As in the previous two surveys, eight out of 10 physicians in group practices were in single-specialty groups.
- Multiple-specialty groups were twice as common in rural than in urban areas.
- The most common physician group size was three to five physicians (38.4 percent).

#### PRACTICE MANAGEMENT/ **TECHNOLOGY**

- Twenty-eight percent of physicians, who responded to the survey, employed mid-level practitioners.
- Eighteen percent of responding physicians utilize temporary help services.
- The most common use of computers in physician offices was for practice billing and receivables and word processing.
- · Almost 80 percent of physicians, up from 50 percent in 1996, who had computers had access to the Internet, most at the office. There also was a great shift from access at home to access at the office (37 percent).
- Ouerving research databases and using email continue to rank at the top of reasons for accessing the Internet.
- •Of those physicians who did not have a computer in their office, the expense of purchasing/maintaining a system remains the top reason given.

#### INSURANCE SERVICES

- Nearly all physicians (95.2) had health insurance coverage. Forty-six percent provided it for their employees and 28.4 percent covered employees' families.
- · Nearly half of physicians were able to select their own health insurance while 30 percent had insurance selected by their practice.
- Nearly half of physicians had their health insurance paid for by their practice.
- Nearly half of physicians had dental insurance, 17 percent provided it for employees, and 11 percent provided it for employees' families.
- · Among other benefits and insurance coverages, more than two-thirds of physicians had life insurance, disability coverage, and pensions.

#### PRACTICE ENVIRONMENT

 More than half of physicians surveyed felt that the supply of physicians in their area and specialty was about the right number, 11.5 said there were too few, and 28 percent said there were too many. The number of physicians citing a shortage declined each year since the survey began, and the number citing an oversupply finally decreased this year.

- Urban physicians and specialists were more likely to feel there is an oversupply, while rural and primary care physicians were more likely to cite and undersupply.
- At least half of physicians said that managed care has not affected patient referrals, information sharing, collegiality or trust among
- Almost half of physicians reported a decrease in income based on the impact of managed care.
- The most common advantage to managed care identified was the ability to expand/retain the patient base (32 percent).
- The most common disadvantage of managed care identified was the loss of autonomy (83 percent) and the potential decrease in income (82 percent).
- In order to prepare for, or adjust to, accepting risk contracts, nearly 80 percent of physicians were evaluating practice costs.
- Nearly half of physicians surveyed joined a physician organization and/or a physician/hospital organization in the last two years.
- •Over half of physicians are considering merging with a group practice in the next two vears.

#### SERVICES

- Fifty-seven percent of physicians provided charity care in their practice, and over half of physicians said that they are providing about the same amount of charity care as they did five years ago.
- One-quarter of physicians donate their medical skills for community service projects, and 41 percent do other non-medical community service work.
  - Rural physicians volunteered at higher rates



than urban physicians did.

• Only 11 percent of physicians were paid for hospital committee work or other peer review activities.

#### **FINANCE**

- •The average gross revenue per physician was \$437,700 in 1998, down from the \$438,800 reported in 1995.
- The average for total professional expenses was \$231,200 in 1998, down from \$244,400 reported in 1995.
- The average net income was \$188,200 in 1998, down from 189,800 in 1995. The median net income was \$160,000 for 1998, as well as for 1995.

#### LIABILITY

- •Up slightly from 1996, half of physicians still purchased their liability coverage themselves in 1998. While the proportion whose liability premiums were paid for by a hospital or by group practices decreased slightly.
- The most common liability coverage was \$200,000/600,000.
- Thirty-five percent of physicians carry a separate set of liability limits to cover a professional corporation.

#### THIRD-PARTY PAYERS

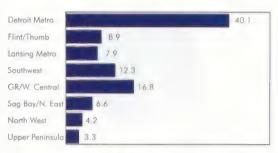
- Eight out of ten physicians participated with Blue Cross Blue Shield of Michigan. Nine out of ten physicians participated with Medicare.
- •Forty-one percent of physicians said that their reimbursement has decreased under Medicare's Resource Based Relative Value Scale (RBRVS).
- While nine out of ten physicians reported that they participated with Medicare in 1998, 59 percent report accepting Medicare on a per case basis.
- •Nine out of ten physicians will accept new patients and intended to sign the 1999 participation agreement.

- Eighty-six percent of physicians accepted new Medicare patients in 1998.
- Half of physicians reported seeing Medicaid patients through contracts with a Qualified Health Plan (includes managed care) and one-third reported seeing Medicaid patients as a participant in the Physician Sponsor plan.
- •Three-quarters of physicians accepted Workers Compensation patients.
- •Nine out of ten physicians contracted with managed care plans; of those who do so, PPO and HMO contracts were the most common.
- Physicians were more likely to contract with managed care plans as part of a PO/PHO compared to 1997.
- Majority of physicians had neither been deselected nor excluded from managed care plans.
- Of those that had not yet contracted with a managed care plan, 32 percent were planning to do so in the coming year.
- Eight-two percent of physicians were subject to pre-authorization programs and 60 percent complied with medical necessity review.
- Only thirty-eight percent of physicians said they have never been prevented from providing a non-covered treatment.
- More than six out of ten physicians had been denied payment retrospectively.
- Nearly half of physicians said that reimbursement policy had an impact on their medical judgement.

#### **DEMOGRAPHICS**

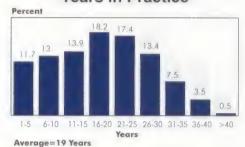
The survey sample was 86.2 percent male and 13.8 percent female. Four out of ten respondents were from the Detroit/Ann Arbor metropolitan area. The average respondent was 50 years old and had been in practice for 19 years. Two-thirds of physicians responding were specialists; in urban areas, 71 percent of physicians were specialists, whereas in rural areas 51 percent were. Nearly half of all respondents attended a Michigan medical school.

#### Respondents by Region

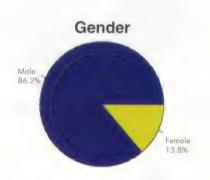


Percent

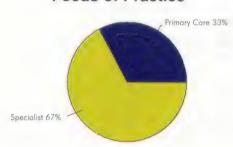
Years in Practice



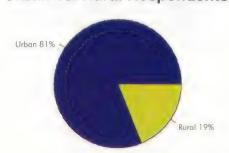




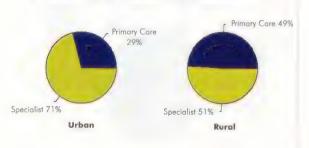
**Focus of Practice** 



**Urban vs. Rural Respondents** 



#### Focus of Practice by Location

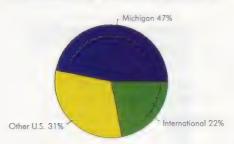




#### **Distribution by Age**



#### **Location of Medical School**



#### PRACTICE ARRANGEMENT

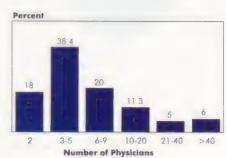
The proportion of physicians in solo practice and in group practice remained stable from 1997 to 1999 at approximately 35 percent and 37 percent, respectively. The percentage of employed physicians increased by two percent. As in the 1995 and 1997 survey, 8 out of 10

physicians in group practices were in single specialty groups. Multiple specialty groups were more common in rural areas than in urban areas. Physician groups of three to five physicians were the most common size group at 38.4 percent.

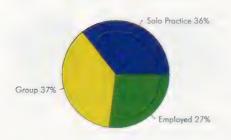
#### Type of Practice

Single physician practice	29.3 %
Single physician/shares expenses	6.4 %
Group Practice	37.2 %
Employed by:	
Managed care organization	0.7 %
Hospital	11.8 %
Professional corp/practice	7.7 %
University/teaching hospital	3.3 %
Other organization	3.6 %

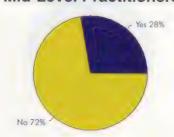
### Size of Physician Groups



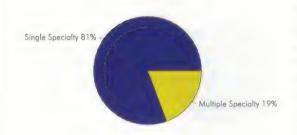
#### **Type of Practice**



#### PhysiciansThat Employ **Mid-Level Practitioners**



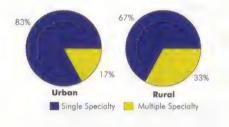
#### Type of Group



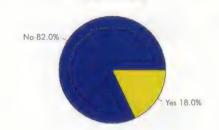
#### **Average Hourly Staff Wages**

Physician Assistant	\$24.77	\$30.80
Registered Nurse	14.05	17.09
Nurse Practitioner	21.64	25.56
Nurse Clinician/Specialist	19.29	25.75
Medical Assistant	8.97	11.84
Imaging Technician	11.51	17.91
Laboratory Technician	11.51	14.30
Manager/Administrator	15.12	18.56
Billing Clerk	10.06	12.61
Receptionist	8.47	10.79

#### Type of Group by Region



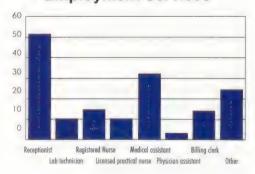
#### **Utilization of Temporary Help** Services



#### PRACTICE MANAGEMENT/ **TECHNOLOGY**

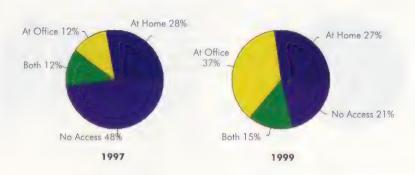
Twenty-eight percent of physicians responding employed mid-level practitioners. Eighteen percent of physicians utilized temporary help services. The most common use of computers was for practice billing and receivables and for word processing. Internet access at the office went from 12 percent in 1997 to 37 percent in 1999, making it the most common place in which physicians have access. Querying research databases and use of e-mail remain the most common reason for accessing the Internet. Of those physicians who reportedly did not have a computer in their office, the expense of purchasing and maintaining a system remained the most common reason.

#### **Positions Filled by Temporary Employment Services**





#### **Physicians with Internet Access**



#### Uses of the Internet

Querying research databases	65%
Point-to-point email	62%
Get information from MSMSNet	38%
Online CME	17%
Consumer-physician exchanges	12%
Other uses 11%	
Medical consultations	3%

#### **Uses of Computer**

Practice billing & receivables	85%
Word processing	73%
General accounting functions	57%
Scheduling	56%
Management reports	49%
Dial to other computers	48%
Claims management	44%
Link to hospital, lab or pharmacy	38%
E-mail/bulletin board	30%
Procider reimbursement	28%
Medical records	19%
Member eligibility	15%
Referrals and authorization	15%

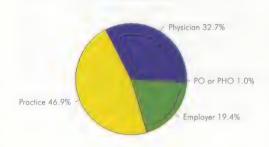
#### Reason for Not Having a Computer

Expense of purchasing/maintaining	39%
Need more knowledge	33%
Insufficiently trained staff	26%
Other reasons	26%
Planning to retire soon	21%

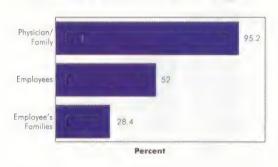
#### **INSURANCE SERVICES**

Nearly all physicians (95.2 percent) had health insurance coverage. Another 52 percent provided it for their employees and 28 percent provided it for employees' families. Half of physicians reported selecting their own health insurance. Nearly half of physicians reported having their health insurance paid for by their practice. Nearly half of physicians had dental insurance, another 18 percent provided it for their employees, and 11 percent provided it for employees' families. Among other benefit and insurance coverages, eight out of ten physicians had life insurance, disability insurance, and pension plans.

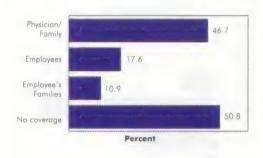
#### Who Pays for Physician Health Insurance



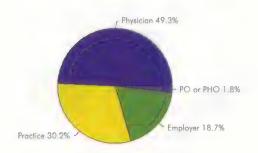
#### **Health Insurance Coverage**



#### **Dental Insurance Coverage**



#### Who Selects Physician Health Insurance



#### Other Physician Coverage

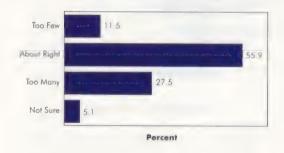
Life insurance	79%
Disability coverage	79%
Pension	75%
Business overhead protection	30%
Vision benefits	25%
Business owners protection	22%
Directors & officers liability	15%
Long term care insurance	13%
Errors and Omissions coverage	7%



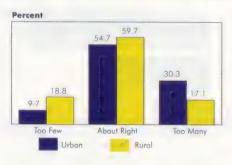
#### PRACTICE ENVIRONMENT

More than half of all physicians surveyed felt the supply of physicians in their area and specialty was about the right number, 11.5 said there were too few and 28 percent said there were too many. The number of physicians citing a shortage declined each year since the survey began, and for the first time since the survey began the number citing an oversupply decreased. Urban physicians and specialists were more likely to feel there was an oversupply, while rural and primary care physicians were more likely to site an undersupply. At least half of physicians said that managed care has not affected patient referrals, information sharing, collegiality, or trust among physicians. Nearly half of physicians reported a decrease in practice income as an impact of managed care. The most common advantage of managed care identified was the opportunity to expand and retain their patient base (32 percent). The most common disadvantage of managed care identified was the loss of autonomy and the potential decrease in income (83 and 82 percent, respectively). In order to prepare for or adjust to accepting risk contracts, 8 out of 10 physicians were evaluating their practice costs. Nearly half of physicians surveyed reported joining a physician organization or a physician hospital organization in the last two years. More than half of physicians are considering merging with a group practice in the next year.

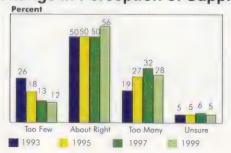
#### Supply of Physicians



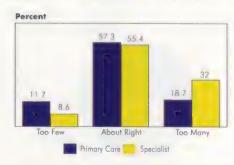
#### Supply of Physicians by Region



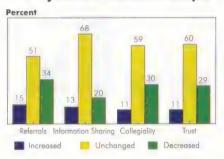
#### Change in Perception of Supply



#### Supply of Physicians by Specialty



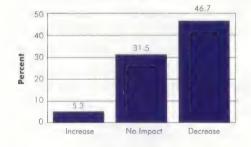
#### **Effect of Managed Care on** Physician Relationships



#### **Disadvantages to Managed Care**

Loss of autonomy	83%
Potential decrease in income	82%
Concern over decrease in quality	76%
Loss of control	68%
Liability concerns	54%
Less power in negotiating	50%
Less career flexibility	37%
No significant disadvantage	3%

#### Impact of Managed Care on **Practice Income**



#### **Steps Physicians Are Taking to Prepare to Accept Risk Contracts**

Evaluating practice costs	79%
Havingcontracts reviewed	41%
Soliciting help from consultants	26%
Obtaining tracking software	14%
Soliciting help from MSMS	11%

#### **Advantages to Managed Care**

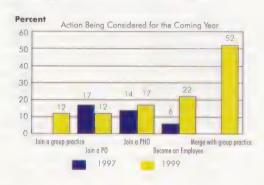
Expand/retain patient base	32%
Greater incentive to coordinate care	18%
Greater incentive for prevention/wellness	15%
Potential increase in income	7%
Focuson patient care	5%
Increase of autonomy	2%
No significant advantage	63%

#### **Organizational Changes**





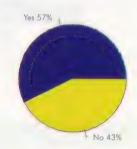
#### **Organizational Changes**



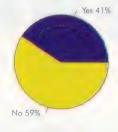
#### SERVICES

Fifty-seven percent of physicians provided charity care in their practice, and over half of physicians said they were providing the same amount of charity care as they did five years ago. One-quarter of physicians donate their medical skills for community service projects, and 41 percent do other non-medical community service work. Rural physicians volunteered at higher rates than urban physicians. Only 11 percent of physicians were paid for hospital committee work or other peer review activities.

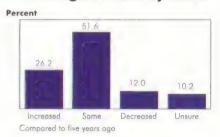
#### **Physicians Providing Charity Care**



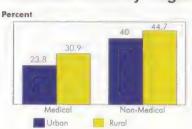
#### Other Community Service Work



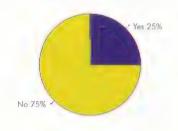
#### **Change in Charity Care**



#### **Volunteer Work by Region**



## Community Services Using Medical Skills

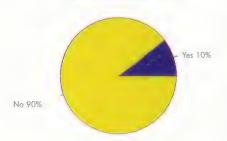


#### **Charity Care and Volunteer Work** Average Per Physician

Free Care	3.0 hours/week
Reduced Fee Care	3.3 hours/week
Volunteer Work:	

Medical 5.1 hours/month Non-Medical 5.8 hours/month

## Physicians Paid for Hospital Committee Work





#### FINANCE

Physicians averaged a very slight decrease (less than 1 percent) in gross revenue in 1998. The average gross revenue per physician was \$437,700 in 1998. The average for total professional expenses was \$231,200. This figure is also down from 1995, about a 5.4 percent decrease. The average net income was \$188,200 in 1998, with a median of \$160,000. While the average net income shows a very slight decrease from 1995 (less than 1 percent), the median remains steady. Because financial figures tend to be influenced by extreme values, the median value may be a better reflection of what the "average" physician experienced in 1998.

#### Gross Revenues Per Physician (in Thousands of Dollars), 1998

Region F	No. of Responses	Mean	Standard Error	25 <sup>th</sup> Percentile	Median	75 <sup>th</sup> Percentile
Detroit/Ann Arbor	197	393.5	20.5	211.0	362.9	487.5
Lower Peninsula – Urban	* 209	503.7	38.6	230.0	353.0	600.0
Lower Peninsula – Rural	91	366.4	33.4	210.0	300.0	440.0
Upper Peninsula	N/A**					
Location						
Urban	428	446.3	21.4	228.3	344.4	500.0
Rural	110	371.1	28.9	210.0	300.0	462.5
Specialty Type						
Primary Care	180	330.0	21.2	210.0	278.5	365.0
Specialist	349	494.5	26.2	238.0	389.0	600.0
Michigan	550	437.7	18.7	215.0	330.0	500.0

<sup>\*</sup>Non-Detroit/Ann Arbor

<sup>\*\*</sup>Insufficient data to report this region

#### Total Professional Expenses Per Physician (in Thousands of Dallars), 1998

Region	No. of Responses	Mean	Standard Error	25 <sup>th</sup> Percentile	Median	75 <sup>th</sup> Percentile
Detroit/Ann Arbor	162	205.8	14.5	100.0	167.5	250.0
Lower Peninsula – Urban*	165	275.5	25.4	119.5	200.0	300.0
Lower Peninsula – Rural Upper Peninsula	75 N/A**	193.3	25.8	76.0	130.0	215.0
Location						
Urban	342	240.5	14.2	109.3	186.0	270.0
Rural	90	196.4	22.3	80.0	132.5	250.0
Specialty Type						
Primary Care	140	211.1	23.4	100.0	161.5	238.8
Specialist	285	242.8	14.5	100.0	190.0	295.0
Michigan	443	231.2	12.1	100.0	175.0	264.0

## Net Income, After Expenses and Bulare Taxes, Per Physician (in Thousands of Dollars), 1998

Region	No. of Responses	Mean	Standard Error	25 <sup>th</sup> Percentile	Median	75 <sup>th</sup> Percentile
Detroit/Ann Arbor	254	184.7	6.5	110.0	166.0	225.0
Lower Peninsula – Urban*	261	197.9	7.8	120.0	168.0	250.0
Lower Peninsula – Rural	105	160.3	8.1	104.6	140.0	200.0
Upper Peninsula	N/A**					
Location						
Urban	543	195.1	5.0	120.0	168.0	240.0
Rural	132	162.8	8.2	105.0	139.0	198.3
Specialty Type						
Primary Care	233	143.3	6.3	100.0	130.0	170.0
Specialist	432	213.7	5.6	130.0	188.5	253.0
Michigan	691	188.2	4.2	115.0	160.0	225.0

<sup>\*</sup>Non-Detroit/Ann Arbor

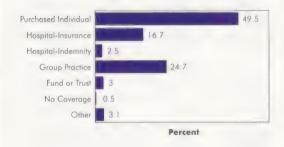
<sup>\*\*</sup>Insufficient data to report this region



#### LIABILITY

Half of physicians still purchased their liability coverage themselves in 1998, this is up 2 percent from 1996. The proportion whose liability premiums were paid for by a hospital or group practice decreased slightly. The most common liability coverage was \$200,000/ \$600,000 (41 percent). Thirty-five percent of physicians carry a separate set of liability limits to cover their professional corporation.

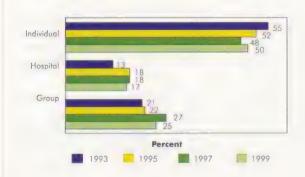
#### Source of Liability Coverage



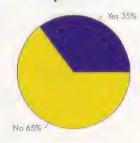
#### Liability Per Case Limit/Annual Limit



#### Source of Liability Coverage



#### **Carry Separate Set of Liability Limits to Cover Professional** Corporation



#### THIRD-PARTY PAYERS

Eight out of ten physicians participated with Blue Cross Blue Shield of Michigan and with Medicare. Forty-one percent of physicians said that their reimbursement has decreased under Medicare's Resource Based Relative Value Scale. Most physicians will accept new Medicare patients and intended to sign the 1999 participation agreement. Nine out of ten physicians accepted Medicaid patients in 1998.

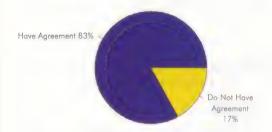
Half of physicians saw Medicaid patients on contract through a Qualified Health Plan, while one-third saw patients as a participant in the Physician Sponsor Plan. Three-quarters of physicians accepted Workers Compensation patients. Nine out of ten physicians contracted with managed care plans; of those that did so, PPO and HMO contracts remained the most common. Physicians were more likely to contract with managed care plans as part of a PO/PHO than in 1996.

The majority of physicians had neither been deselected or excluded from managed care plans. Of those that had not yet contracted with a managed care plan, 32 percent were planning to do so in the coming year.

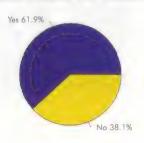
Eighty-two percent of physicians were subject to pre-authorization programs, and 59 percent complied with medical necessity review. Only 38 percent of physicians said they have never been prevented from providing a noncovered treatment. More than 6 out of 10 physicians had been denied payment retrospectively. Nearly half of physicians said that reimbursement policy had an impact on their medical judgement.

The author is assistant to Health Care Research at MSMS.

#### 1999 Blue Cross Participation



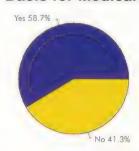
#### Accept Assignment on a Per Case Basis for BCBSM



#### 1999 Medicare Participation

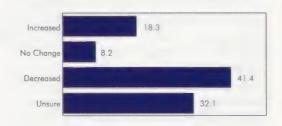


#### Accept Assignment On a Per Case Basis for Medicare





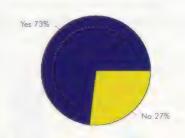
#### **Reimbursement Under RBRVS**



#### **Comparison of RBRVS** Reimbursement Response



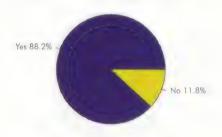
#### **Accept Workers Compensation Patients**



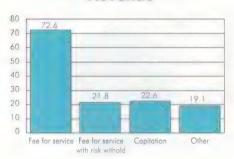
## Reasons for Not Seeing Workers Compensation Patients

Delays/denials of patient eligibility	52%
Other payment issues	52%
Reimbursement	50%
Delays/denials of patient eligibility	49%
Fiscal audit experience	32%

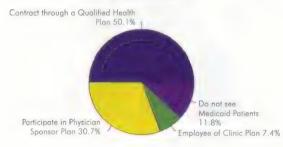
#### **Accept Medicaid Patients**



## Average Source of Practice Revenue



#### **How Physicians See Medicaid Patients**



## Physicians Subject to Utilization Review

Second surgical opinion	43%
Preauthorization	82%
Medical ncessity review	59%
Laboratory service review	21%
Concurrent review	27%

#### **Future Medicare Participation**

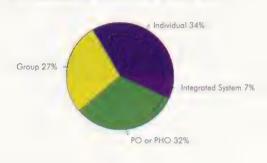




**Physicians with Managed Care** Contracts



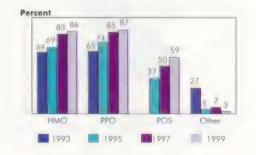
#### Contracted with the Plan as...



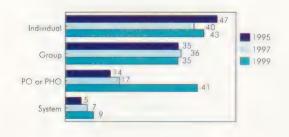
**Types of Managed Care Contracts** 



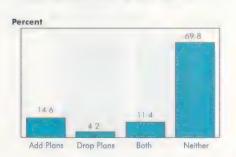
**Type of Managed Care Contracts** 



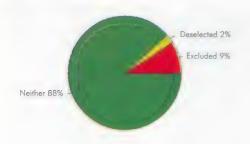
**Change in Contracting Method** 



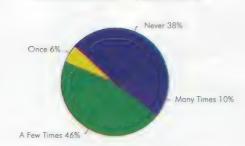
Plan to Change Managed Care Affiliations in 1999



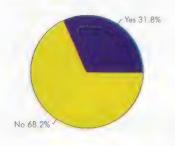
#### **Physicians Deselected or Excluded by Managed Care Plans**



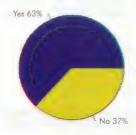
#### **Prevented from Providing Noncovered Treatment**



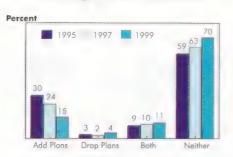
#### **Considering Signing with First Managed Care Plan**



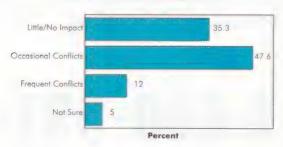
#### **Been Denied Payment** Retrospectively



#### **Change in Affiliations**



# Impact of Reimbursement Policy on Medical Judgment





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# Physicians Use Travel to Enhance Lives, Personal Growth

By Ralph D. Ward



**Great Accomplishment**—Sadavisa T. Reddy, MD, (left) and Rama Swamy (right), principal, join members of the college staff in front of the College of Medical Sciences, Bharatpur, Nepal.

# Sadasiva Reddy, MD: Mission to Nepal

Physicians who emigrated to the United States from other lands have provided Michigan with cultural richness and quality care. Many of these physicians also have helped awaken our sensitivity to the health needs of other countries. With their awareness of the often severe health care shortfalls in other nations, these physicians are leaders in efforts to improve medical care in their country of origin. This commitment even extends to other underserved countries, as shown by the work of Sadasiva Reddy, MD, and the International Society of Medical Education (ISME).

Doctor Reddy, a radiologist affiliated with Foote Hospital in Jackson, emigrated from India in 1969, and since has been instrumental in aiding health care in his home country, helping to launch both a medical school and a clinic. However, Doctor Reddy and a number of U.S.-based physicians from India grew concerned over the even greater unmet health care needs

in the neighboring nation of Nepal. "Nepal is not that developed, and a number of us physicians from India thought we should do something."

In 1994, Doctor Reddy and four other physicians launched the International Society as a tax-exempt charitable body to help with care in Nepal and other lands. By working with the government of Nepal and digging into their own pockets, the group built a 300-bed

hospital in a remote area of the country.

Of greater long-term benefit, however, is the College of Medical Sciences the ISME helped to establish in Bharatpur, Nepal. Begun in 1996, the college today has 300 students from Nepal and a faculty and staff of 70, mostly from India. "We planned to offer a six-year U.S.-type medical school model, but that just wasn't practical, so we now offer a four-year European program," says Doctor Reddy.

Scholarship money raised by the ISME allows 20 percent of the students to attend at no cost, while the rest are subsidized by the Nepalese and Indian governments. A residency program and specialty training are in the works for the medical school.

The success of ISME's work in Nepal depends heavily on volunteer effort, and Doctor Reddy helps conduct two-week physician group tours to Nepal that combine sightseeing, education, and providing local care. "It's a combination of sightseeing and a conference that's been very successful," notes Doctor Reddy. "We took 17 people in February and March of this year."

#### Breathtaking view-Pinnacle Rock, Bartolome Island, Galapagos Islands. Part of the enchantment of the Galapagos are the islands' lack of commercialization and sheer isolation



Lost City of the Incas-An arial view of the ancient Incan city of Machu Picchu. These reconstructed ruins of stairways, terraced hillsides, alters, fountains, and temples once housed over 3,000 people.

Bird's Eye View-The Duhamels and traveling companions Doctor and Mrs. James Hubner (left) sit on the highest wall of Machu Picchu. Notice the cloud cover behind them!

Doctor Reddy has traveled to Nepal yearly since 1993, and ultimately plans a "semi-retirement" of half the year at his practice in Michigan, and half working in Nepal.

Doctor Reddy takes great personal satisfaction in his work with the ISME "We're lucky here in the United States, and as doctors, we can help educate people, and make lives better." Doctor Reddy asks that physicians planning to travel in the India region consider joining one of the tours to "go teach and

treat for one or two weeks," and also asks for tax-deductible donations of equipment or instruments. For more information contact him at (517) 592-3109, or at sadasiva@umich.edu.

## Peter Duhamel, MD: A Visit to the Incas

Peter Duhamel, MD, has a long history of leadership with MSMS, including a term as

president of the society, and is a respected Rochester-based surgeon. But he and his wife Lois also are known to friends as seasoned globetrotters.

Avoiding the standard tourist traps, the Duhamels prefer to explore the offbeat, exotic, and challenging. A recent example was their February South American trek; two weeks that took them to Peru, the lost mountain city of Machu Picchu, and the natural marvels of the



Hemispheres unite—Doctor and Mrs. Duhamel join the Northern and Southern Hemisphere as they stand on the equator. Doctor Duhamel is standing in the Southern hemisphere while Mrs. Duhamel is in the Northern.

Galapagos Islands.

But we'll let Doctor Duhamel recount his own travelogue:

"In February we flew into Lima, Peru, arriving at night. We stayed that night at the Swissotel, and the next day took a tour of the city, a very interesting place.

"When Spain conquered Peru in the 1500s Lima wasn't a city at all, just waterfront, so it was founded and built as a Spanish city. The old cathedral in Lima is very impressive, and we saw the grave of Francisco Pizarro, who founded Lima in 1535.

"A few days after arriving, we went up to Cuzco in the Andes Mountains. Cuzco was the ancient Inca capital, and many of the old Incan walls and temples are still standing. We stayed at the Libertadore hotel in Cuzco, the jumping-off point for the ancient city of Machu Picchu.

"The usual trip to Machu Picchu is by an old narrow-gauge railroad. It's a 3 ½-hour trip each way, and the travel along takes up most of a day, so we arranged to stay there overnight. But there was a heavy rain shortly before our arrival, and a mudslide covered the tracks, so instead of the train we went by helicopter—and that trip was only 25 minutes!

"Machu Picchu was a high point of our trip. It was never discovered by the Spaniards, so it was never sacked or desecrated. It's a very impressive place, and housed about 3,000 people at its peak. It was built in two levels, the upper levels, with temples and palaces, were where the leadership lived, and the lower levels were for the people. They had terraced farms on the mountains where they grew crops like squash,

Booby acquired its name because of their absurd tameness. They are sea dwellers and avid fishermen.

sweet potatoes, and maize. We stayed the night at an offsite hotel, the Ruines, then went back for more touring the next morning before heading back to Cuzco. Taking the helicopter let us be more than day trippers!

"The next day we went to Lima, and from Lima we flew up to Quito in Ecuador, where we visited the native markets and crossed the equator-in fact, we stood on it! From there we flew to Guayaguil, where we took the 800-kilometer flight to the Galapagos Islands. The Galapagos are famous for the work of Charles Darwin, who wrote the Origin of Species in part about the incredible animals and birds he found there. We visited six of the 50 islands. We saw the large land tortoises, and land and sea iguanas. We were able to swim with sea lions. They have no fear of man, and neither do the native birds—you can go up and pet them. The only animals that fear man are the non-native animals, like wild dogs and cats. These are overrunning the islands, by the way, and threatening the native species. Also, El Nino last year caused a lot of damage. We took a cruse ship from island to island for four days and three nights.

"We returned home after 13 days. It was a busy trip—we slept most of the first week after we came back."

The author is a Riverdale-based freelance writer.

### NEWSMAKERS



Kenneth C. Palmer, MD, PhD, was recently appointed Assistant Dean of Graduate Programs for the Wayne State University School of Medicine. In this position, Doctor Palmer will be responsible for the curriculum and program development of the basic medical sciences graduate program. An associate professor of pathology, Doctor Palmer has been director of the pathology graduate program since 1981.

Kathleen Yaremchuk, MD, director of the Smell and Taste Clinic at Henry Ford Health System recently was named president of the Michigan Otolaryngological Society. Doctor Yaremchuk is the first woman to be elected to this position in the organization. For the past 11 years, she has served as the University of Michigan Medical School clinical instructor in the department of Otorhinolaryngology.



Anders Sima, MD, PhD, professor of pathology and neurology at the Wayne State University School of Medicine, has been named one of the 2000 Outstanding Scientists of the 20th Century by the University of Cambridge. Doctor Sima will be featured with other honorees in a book compiled by the International Biographical Centre at Cambridge. He is an internationally recognized expert on diabetic neuropathology and dementia, and has made many original contributions to the health science field.

Richard Zarbo, MD, DMD, vice chair and director of anatomic pathology at Henry Ford Hospital, recently was awarded the College of American Pathologists Foundation's Lansky Award. The award is presented to board-certified pathologists who have demonstrated leadership and significant contributions to the field of pathology. Doctor Zarbo serves as coordinator of the anatomic pathology residency training program at Henry Ford Health System.



John H. McLaughlin, MD, recently was elected chair of the MSMS Organized Medical Staff Section. Doctor McLaughlin also is a member of the MSMS Board of Directors and chair of the MSMS Publications Committee.



Peter A. Levine, MPH, recently received the Clement A. Alfred Humanitarian Award. This award has been given annually in recognition of those health care professionals who demonstrate the level of dedication to their professions and concern for their community, as has Doctor Alfred throughout his career. Levine is the executive director of the Genesee County Medical Society.

## NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine. the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Vasudev Ananthram, MD Jackson Paul J. Arpasi, MD Royal Oak Stephen J. Bachmeyer, MD Tecumseh Keith D. Bailey, MD Kalamazoo Narinder K. Batra, MD Tecumseh Saad A. El-Naggar, MD Jackson Brian T. Eller, MD St Joseph Stephanie E. Falbo, MD West Bloomfield

Lisa R. Ferley, MD St Joseph Kristine M. Gibson, MD Portage Brian P. Giersch, MD Grand Rapids William Kokx, DO Iron Mountain Michael G. Krogulecki, DO Lansing John E. LaGorio, MD Muskegon John P. LaGrand, MD Grand Rapids Barton McLean Lewis, DO Plainwell Mihaela A. Lupu, MD Dearborn Sved A. Mahmood, MD Harbor Beach

Paul R. Makela, MD Detroit Scott M. Moore, MD Jackson Daniel M. Ockner, MD Grand Rapids

William Oduro, MD Jackson Anthony H. Palmer, MD St Joseph Todd A. Phillips, MD Kalamazoo Shailaja Pulisetty, MD Morenci

Joseph Renney, DO St Joseph Miraflor T. Reyes, MD Jackson Ginene Rogler-Brown, MD St. Joseph Evgueni Roudachevski, MD Grand Blanc Aaron D. Samuel, MD Iron Mountain Charles E. Smart, MD Troy Souha Sultan-Hakim, MD lackson Ellen M. Tambunan, MD Cassopolis Amy C. VanderWoude, MD Grand Rapids Sasikala Vemuri, MD Flint

## **OBITUARIES**

Clifford L. Doane, MD, died on February 26, 1999. He was 64. Doctor Doane, a former Clinton Township pediatrician, graduated from Wayne State University College of Medicine in 1965. He served in the Navy from 1953-57. Doctor Doane was a member of Detroit Pediatric Society, Macomb County Medical Society, and MSMS.

Quincey C. Fan, MD, died on February 28, 1999. He was 83. Doctor Fan, a Flint internist, graduated from St. John's University in 1942. He was Chief of Internal Medicine in the Air Force from 1955-57. Doctor Fan was a member of the Society of Internal Medicine, Genesee County Medical Society, AMA, and MSMS.

Frank W. Garber III, MD, died on March 15, 1999. He was 69. Doctor Garber, a Grand Rapids ophthalmologist, graduated from Wayne

State University College of Medicine in 1955. He served in the Army from 1956-58. Doctor Garber was a member of Muskegon County Medical Society and MSMS.

Charles P. Hodgkinson, MD, died on December 29, 1998. He was 91. Doctor Hodgkinson, an OB/GYN, graduated from Temple University Medical School in 1936. He served as captain in the U.S. Medical Corps from 1942-46. Doctor Hodgkinson was a member of the American Association of Obstetricians and Gynecologists, the Michigan Society of Obstetricians and Gynecologists, Wayne County Medical Society, the AMA, and MSMS.

Robert H. Hume, MD, died on February 27, 1999. He was 76. Doctor Hume, a Kalamazoo general surgeon, graduated from the University of Michigan Medical School in 1948. He served as captain in the Army from 1953-55. He was a member of the American College of Surgeons, Michigan Society of Abdominal Surgeons, Kalamazoo Academy of Medicine, and MSMS.

William T. Hyslop, MD, died on February 13, 1999. He was 86. Doctor Hyslop, a Traverse City psychiatrist, graduated from the University of Louisville medical school in 1936. He was a member of the Michigan Psychiatric Association, Michigan Society for Psychiatry and Neurology, Saginaw County Medical Society, and MSMS.

Jerome F. Mancewicz, MD, died in February 1999. He was 72. Doctor Mancewicz, a Grand Rapids general practitioner, graduated from the University of Michigan in 1956. He served in the Army from 1945-49. Doctor Mancewicz was a member of the Western Michigan Academy of Family Practice, Kent County Medical Society, AMA, and MSMS.

D. W. Vander Vliet, MD, died March 4, 1999. He was 57. Doctor Vander Vliet, a Grand Rapids child psychiatrist, graduated from the University of Michigan Medical School in 1968. He served as major in the Air Force from 1972-74. Doctor Vander Vliet was a member of the Michigan Society for Adolescent Psychiatry, Michigan Psychiatric Association, American Psychiatric Association, and MSMS.

Arno A. Whipple, MD, died January 25, 1999. He was 80. Doctor Whipple, a Mooresetown general surgeon, graduated from medical school in 1947. He served in the Navy from 1945-46 and in the Army from 1952-1954. He was a member of Wexford-Missaukee County Medical Society.

## DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Consumer and Industry Services, Office of Health Services.

Name: Michael D. Ward, MD, 40000 Grand River #105, Novi, MI 48375

Action, Date Taken: 02-21-99; Summary Suspension Dissolved

Name: Charles M. Asplund, MD, 2437 Hampton Court, SE, Grand Rapids, MI 49546

Action, Date Taken: 02-24-99; Probation—2 yrs.; Fine—\$5,000.00

Reason: Negligence/Incompetence

Name: Marie E. Bem, MD, 2622 Abbott Rd., Midland, MI 48642

Action, Date Taken: 02-16-99; Voluntary Surrender of License; Summary Suspension Dissolved

Reason: Technical Violation of the Public Health Code

Name: Zach B. Brown, MD, 14438 W. McNichols, Detroit, MI 48235

Action, Date Taken: 03-25-99; Fine—\$24,000.00; Community Service

Reason: Probation Violation

Name: Paul M. Byrnes, MD, Bixby Medical Center, 901 Kimole Ln., Suite A2, Adrian, MI 49221

Action, Date Taken: 03-01-99; Probation—6 mo.; Reprimand

Reason: Negligence/Incompetence

Name: Peter Palmer, MD, 4806 Rogers Hwy., Britton, MI 49229

Action, Date Taken: 03-26-99; License Suspended—6 mo.; Fine—\$1,000.00

Reason: Failure to Meet Continuing Education Requirements

Name: Daryl T. Parker, MD, PO Box 287, Milan, MI 48160

Action, Date Taken: 02-24-99; Probation—2 yrs.; Reprimand; Fine—\$1,000.00; Final Order dated 12-23-98 is Rescinded.

Reason: Failure to Meet Continuing Education Requirements

Name: Russell C. Thompson, MD, 800 East Columbia, Ste. B, Mason, MI 48854

Action, Date Taken: 02-16-99; Probation—3 vrs.; commencing 6-12-98; Fine—\$500.00

Reason: Mental/Physical Inability to Practice

Name: Kenneth G. Wilhelm MD, 5333 McAuley Dr., Box R7000, Ypsilanti, MI 48197

Action, Date Taken: 03-03-99; Limited License; Probation—concurrent w/limited license

Reason: Violation of General Duty/Negligence

Name: Sharadchandra B. Patel, MD, 4832 Pebworth Place, Saginaw, MI 48603

Action, Date Taken: 03-04-99; License Summarily

Suspended Reason: Criminal Conviction

# **Evaluate Your Answering Service**

Does Your Message System Improve Your Practice, Increase Patients' Peace of Mind?

By Gregory Brusstar

ave you evaluated your answering service lately? As a physician, you should make sure you're getting reliable service and performance from your answering service.

After all, your quality of life after hours is on-the-line, so to speak.

An excellent answering service should improve your quality of life while increasing your patients' peace of mind, says Richard Ambs, owner of Lansing- and Jackson-based Ambs Message Center.

"You should expect consistency, accuracy of messages, follow-up of unanswered pages, an ability to follow specific instructions, and documentation of calls," said Ambs, whose company has provided service to physicians and businesses for 20 years. "While occasional errors will occur, the message system should have safeguards built in to prevent them."

Some safeguards, he says, include speed-dial programming to ensure accuracy of numbers paged, an automatic on-screen alert when a call needs to be paged out again, an on-screen instructions display when a call is received on a physician's line, and audio-recording of all calls.

—Brian Adamczyk, MD

"It's a personal

touch that you

don't get with

voice mail and

the patient . . .

Also, it's easy

for us to call the

operator at any

time and make

changes to

our calling

instructions."

it's reassuring to

#### Live or Voice Mail Service?

When it comes to choice of services, most physicians prefer to use live service in combination with "alphanumeric" paging. The phone message is taken by an operator and then relayed to an alphanumeric pager, which displays a detailed phone message that can be several sentences long.

The displayed message is long enough for the physician to determine what the problem is and what action needs to be taken, if any. Physicians find it more efficient and convenient than a numbers-only display. This also reduces their cellular phone bill.

In addition, with live service a physician is

able to leave specific messages for patients or other physicians with the operator.

Jackson family practitioner Brian Adamczyk, MD, believes live answering provides better service to patients and is convenient

for physicians.

"It's a personal touch that you don't get with voice mail and it's reassuring to the patient," said Doctor Adamczyk. "Also, it's easy for us to call the operator at any time and make changes to our calling instructions."

The choice of live or voice mail service sometimes depends on the physician's specialty and patient mix. Live service—since it takes people to operate—is more expensive than voice mail.

Those physicians who are comfortable with the voice mail option can realize significant savings over live service.

"Our group of seven was paying well over \$600 per month for service until we switched to a voice mail system," said Lansing neurologist Glen Ackerman, MD. "We're very satisfied with what the service does for us and we reduced our bill to \$240 a month." The service option Doctor Ackerman selected was voice mail with immediate page notification when a voice message is received.

Also available are combinations of live service and voice messaging. For example, a call-screening service provides screening of non-urgent calls (such as appointment cancellations and prescription refills) and diverts them to voice mail. If the call is urgent, the caller has the option to connect to a live operator, who takes the message and immediately pages the physician.

#### **Built-In Safeguards**

The number one attribute for an answering service must be reliability, Ambs says, because physicians can incur liability if they are unavailable during an on-call period. That's why an

answering service must have built-in safeguards to ensure calls get through and are properly documented, he says.

The first safeguard is establishing protocols to ensure physicians are contacted and recontacted when they do not answer their pages.

"Failsafes are important," said Lansing obstetrician/gynecologist Edwin C. Weathington, MD. "If for some reason I don't answer a page, they [answering service] go the extra mile to find me."

With an automated (voice mail) service, physicians don't have the benefit of this repaging safeguard because there's no operator mediating the call. This is definitely one of the drawbacks of a fully-automated service. That's why many physicians select a package with a live component to call answering.

Another safeguard is recording all calls. Many message centers retain an audio copy of all calls for a period of time. This feature has proven valuable in patient/physician conflict resolution.

Providing detailed documentation of all calls that go through the answering service is another important safety measure. Statistical information that should be provided to a customer includes ring time, call duration, operator identification, time of call, time of page, telephone number paged, average ring time, average call duration, and average hold time.

This information can be used to review your answering service's performance as well as to review your group's after-hours practice activity.

In short, don't take your answering service for granted. Since this service is important to your after-hours business and your general wellbeing, you should evaluate it and make sure it's delivering high-quality service and keeping you and your patients satisfied.

The author is an Okemos-based freelance writer.

#### **Important Considerations for** Selecting or Evaluating an **Answering Service**

- Staff training. Inquire about operator training methods. Industry standards include call simulation programs on CD-ROM and call monitoring. Ask about employee turnover rate. That can be an indication of commitment to quality and to employees.
- Third-party evaluation. Ask if the service has been evaluated by the Association of TeleServices International (ATSI). ATSI bases its performance ratings on courtesy, response time, accuracy, and overall customer service. Only a handful of answering services receive ATSI's Award of Excellence. Ambs Messaging was a recipient of the award last year. While you can't expect all answering services to have received this award, it's a good sign if your answering service has sought an ATSI evaluation.
- Error and Omissions insurance. Make sure the answering service carries errors and omissions insurance to cover their liability. Ask for proof.
- References. Get a list of customers and call four or five of them to ask them to frankly tell you about their satisfaction level with the service.
- Your own test. Start with a colleague or a reference who subscribes to the service you'd like to test. Tell your colleague that you will be calling to test the service. When you call, note the operator's courtesy and knowledge. Then check the message accuracy and response time with your colleague.

"Failsafes are important ... If or some reason I don't answer a page, they onswering service go the extra mile to find me."

-Edwin C Weathington, MD

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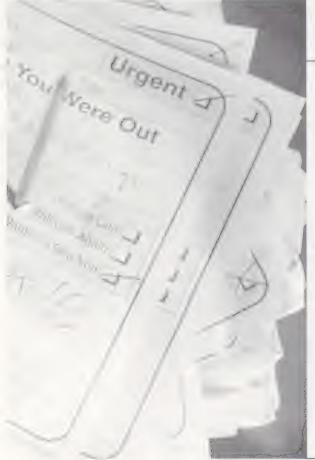
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#### **MSMS** Meetings JULY

- 7, MSMS Risk Management Committee. Location: MSMS Headquarters, East Lansing, MI. Contact: Peggy Galloway at (517) 336-5729 or pgalloway@msms.org.
- 15-18, MSMS Board of Directors Mid-Summer Meeting. Location: Crystal Mountain Resort, Thompsonville, MI. Contact: Irene Frost at (517) 336-5734 or ifrost@msms.org.
- 27, MSMS/MICOA Making the Rounds. Location: Ingham Regional Medical Center, Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.

#### **SEPTEMBER**

- 1, MSMS Committee on Bioethics. Location: MSMS Headquarters, East Lansing, MI. Contact: David K. Fox at (517) 336-5731 or dkfox@msms.org.
- 2, MSMS CME Accreditation Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at (517) 336-5727 or scressman@msms.org.
- 14, MSMS/MICOA Making the Rounds. Location: Lakeland Hospital, St. Joseph, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 14, MSMS Committee of Hospice Medical Directors. Location: **MSMS** Headquarters, East

- Lansing, MI. Contact: Rebecca Blake at (517) 336-5746 or rblake@msms.org.
- 15, MSMS CME Programming Committee Meeting. Location: MSMS Headquarters, Lansing, MI. Contact: Sarah Cressman at (517) 336-5727 or scressman@msms.org.
- 15, MSMS Committee on State Legislation & Regulations. Location: MSMS Headquarters, East Lansing, MI. Contact: Greg Aronin at (517) 336-5739 or garonin@msms.org.
- 15, MSMS/MICOA Making the Rounds. Location: St. Mary's Hospital, Grand Rapids, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 17, MSMS Joint Physician Executive Organization Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.
- 22, Clinical Trends in Pain Management Video Conference Program - Pain Management in Context of End-of-Life Care. Location: Call for nearest Host Site. Contact: Holly Plunkett, MHA at (517) 323-3443.
- 22, MSMS Group Practice Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Mary Anne Ford at (517) 336-5721 or maford@msms.org.

- 29, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Irene Frost at (517) 336-5734 or ifrost@msms.org.
- 29, MSMS Committee on Aging. Location: MSMS Headquarters, East Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.

#### **OCTOBER**

- 13, MSMS Risk Management Committee. Location: MSMS Headquarters, East Lansing, MI. Contact: Peggy Galloway at (517) 336-5729 or pgalloway@msms.org.
- 15-16, MSMS Mackinac Island Conference on Bioethics - Integrity in the Face of Change. Location: The Grand Hotel, Mackinac Island, MI. Contact: David K. Fox (517)336-5731 dkfox@msms.org.
- 20, MSMS Committee on Bioethics. Location: MSMS Headquarters, East Lansing, MI. Contact: David K. Fox at (517) 336-5731 or dkfox@msms.org.
- 26, MSMS / MICOA Making the Rounds Program. Location: Ingham Regional Medical Center, Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.

#### NOVEMBER

3-5, 134th MSMS Annual Scientific Meeting. Location: Ritz Carlton, Dearborn, MI. Contact: Brenda Menzies at (517) 336-7580 or bmenzies@msms.org.

10, MSMS Committee on State Legislation & Regulations. Location: MSMS Headquarters, East Lansing, MI. Contact: Greg Aronin at (517) 336-5739 or garonin@msms.org.

12, MSMS/MICOA Making the Rounds. Location: Munson Medical Center, Traverse City, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.

17, MSMS Board of Directors Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Irene Frost at (517) 336-5734 or ifrost@msm.org.

#### **DECEMBER**

2, MSMS CME Accreditation Committee Meeting. Location: MSMS Headquarters, Lansing, MI. Contact: Sarah Cressman at (517) 336-5727 or scressman@msms.org.

15, MSMS CME Programming Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Sarah Cressman at (517) 336-5727 or scressman@msms.org.

15, MSMS Committee on Aging. Location: MSMS Headquarters, East Lansing, MI. Contact: Tom Plasman at (517) 324-6958 or tplasman@micoa.com.

#### **SPECIALTY SOCIETIES** JULY

21, Michigan Society of Respiratory Care Pulmonary Rehab Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **AUGUST**

6, Michigan Society of Respiratory Care Board Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **OCTOBER**

1, Michigan Society of Respiratory Care Board Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **NOVEMBER**

12, Michigan Society of Respiratory Care - Asthma "Sharing" Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

16, Michigan Society of Respiratory Care Pulmonary Rehab Committee Meeting. Location: MSMS Headquarters, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **DECEMBER**

3, Michigan Society of Respiratory

Care Board Meeting. Location: MSMS Headquarter, East Lansing, MI. Contact: Liz Foster at (517) 336-7587 or efoster@msms.org.

#### **AMA MEETINGS** DECEMBER

5-8, AMA Interim Meeting. Location: San Diego, CA. Contact: Julie Lester at (517) 336-5768 or ilester@msms.org.

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# Help Us Find Doctors and Their Families Who Make a Difference

By Peter A. Duhamel, MD, president, MSMS Foundation

ames R. Dehlin, MD, of Gladstone, has been active with the local Boy Scouts for the past 40 years. David K. Johnson, MD. Lansing, has worked as a volunteer coach with the Okemos Athletic Klubs program since the 1980s. Jim O'Connor, DO, formerly of Jackson, now lives with his wife, Connie, in a remote village in Bolivia, where he runs a clinic for isolated natives who need medical care. These are just a few of the doctors and their families making a difference in their communities.

MSMS and the MSMS Alliance, along with partners Mutual Insurance Corporation of America (MICOA) and Stratton Cheeseman & Walsh, would like to recognize other physicians like Doctors Dehlin, Johnson, and O'Connor, who volunteer their time in their communities. Under the auspices of the MSMS Foundation, the 3<sup>rd</sup> annual "Michigan Doctors and Their Families Make a Difference" project encourage and recognizes Michigan physicians and their families for their volunteer efforts.

We need your help in finding physicians who are helping others in their communities. Using the form on page 58, anyone may nominate physicians and their families for recognition of their community service activities. The deadline for entries is August 1, 1999.

All nominees will be recognized in Michigan Medicine, Alliance, county medical society, MICOA publications, on the MSMS Web site, and in statewide and local media. Watch for further details about how you can join the statewide project to benefit family crisis shelters.

Building on last year's successes the 1999 campaign offers the following opportunities:

• Join a statewide effort in October to gather personal supplies for family crisis shelters

- Participate in other needed volunteer efforts identified by the Michigan Community Service Commission
- Recognize volunteer efforts of Michigan physicians and their families in a special October Michigan Medicine insert



"Our colleagues and their families across the state do so many good things to benefit their communities," acknowledges MSMS President Krishna K. Sawhney, MD. "We think it is important to give them a pat on the back for their service."



"By sponsoring our own project and identifying others who need willing hands and hearts, we seek to encourage those who have not vet become involved in community service," adds Sue Van Tuinen, MSMS Alliance president.

The "Doctors and Their Families Make a Difference" campaign will tie in with National Make a Difference Day, Saturday, October 23, a volunteerism promotional effort of Gannett Newspapers' USA Weekend magazine and of the National Points of Light Foundation.



## "Doctors and Their Families Make a Difference"





# Recognition Form

Deadline for entries: August 1, 1999

Again in 1999, MSMS, MSMS Alliance, MICOA and Stratton Cheeseman & Walsh will recognize physicians and their families for their many and varied volunteer efforts. Please send us a brief description of your volunteer activities, or the activities of a colleague you wish to have recognized.

All participating physicians and their families will be highlighted in the October 1999 issue of *Michigan Medicine*, and their stories may be included in other promotional material. This will be done in coordination with national "Make a Difference Day," Saturday, October 23, 1999.

Physician's Name	Family Members' Names/Relationship	Description of Volunteer Activities:
Specialty		
Address		
City/State/ZIP	_	_
Phone		
ax		
Email		

Please attach a photo depicting the volunteer activity, or a family photo of those to be recognized.

Mail to:

MSMS – Make a Difference P.O. Box 950 East Lansing, MI 48826-0950

Or send email with this information to: jmarr@msms.org

For further information, contact:

Judith E. Marr Executive Director MSMS Foundation 517-336-5744 imarr@msms.org





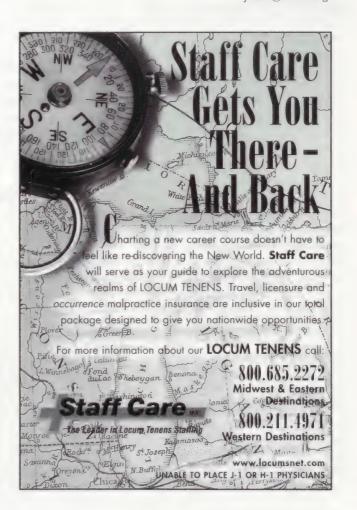
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The Facts and Fiction of Physician Compliance: Fraud and Abuse Laws and Regulations

Thursday, July 22, 11:30 a.m.-4:00 p.m. Location: Kellogg Center, East Lansing Fee: \$50.00 (program only) \$75.00 (program with lunch)

For more information regarding this program, please contact Chuck Cuzydlo at MSMS at (517)336-5714 or ccuzydlo@msms.org.



Would you like to place an ad? The rate for classified advertising in Michigan Medicine is \$1.00 per word, with a minimum charge of \$50.00. Copy for classified advertisements should be received no later than the first of the month preceding the month of publication. To place an ad, contact Kristen Lare, managing editor, at (517) 336-5747 or fax (517) 336-5797.

#### POSITION AVAILABLE

Primary care responsibility in Internal Medicine—in Michigan's Upper Peninsula, Available to permanent residents and American Citizens. Send CV, salary requirements, and references to: Human Resources, 502 West Harrie Street, Newberry, MI 49868.

A significant opportunity for one or more Board Certified internists to take over a seasoned practice that is on a large and well-located site in Farmington Hills. This practice is large and vibrant (18,000 patients per year) but there is room and demand for more services. This is right for a person(s) who have good medical skills and are good managers or have personnel to handle that part. The bank is willing to help with financing for the right applicant. For an appointment to visit the facility and meet the present owners, call (248) 548-4646 and ask for Herb Silverman, Practice Broker and Physician Advisor. Fax CV or any other info you wish to share on your background to (248) 548-0069, Candidate should be a visionary and interested in the latest procedures and the growing demand for alternative medicine. The practice will gross \$1.4 million in 1999. The expected gross for the year 2000 is \$2 million—it's all up from there.

OB/GYN practice located in Michigan's scenic Upper Peninsula is seeking a BC/BE OB/GYN to join a well-established, thriving solo practitioner and PA-C. Potential for future partnership and acquisition. Salary guarantee, full benefit package, and relocation assistance. The area offers a wide variety of outdoor activities in

all seasons, with access to many lakes/ streams and national forests. For further information contact Jacki Courney at (800) 236-3240 or Kathie Owens at (906) 779-1291.

Family practitioner—Certified rural health center in scenic Northern WI is seeking a BC/BE family practitioner who does OB to join a well-established practice. Salary guarantee, full benefit package, loan assistance, and relocation assistance. The area offers four seasons of recreational activities, a safe community environment, good education systems. For further information contact Jacki Courney at (800) 236-3240.

#### PRACTICES FOR SALE

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Dental Practice—Oakland County. Includes building & equipment. Long-established practice in excellent location.

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We have prospective purchasers for medical and dental practices in Michigan. If you are considering selling a practice, give us a call, we may already have a buyer.

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available medical and dental properties in Wayne, Oakland and Macomb Counties. Give us a call and we will develop a list of properties that meet your requirements. We keep all inquiries confidential! Also, call for a free copy of our listing catalog. McNabnay & Associates, Inc. (248) 258-5900 Medical Building Specialists.

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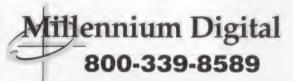
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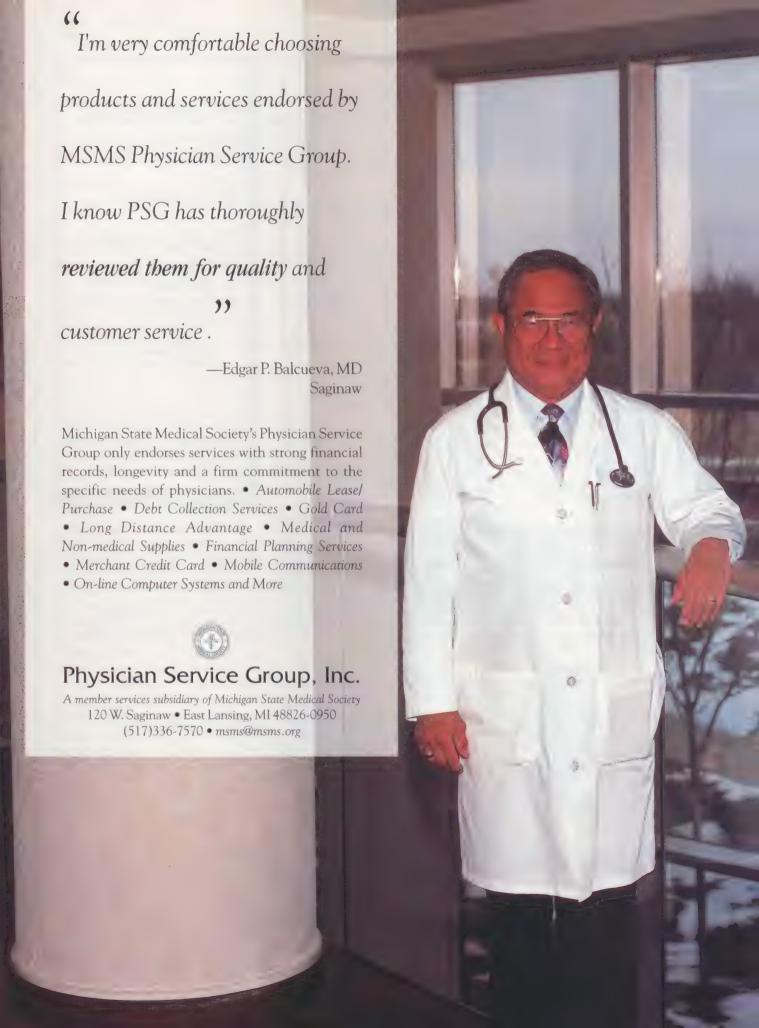
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# Physician's Catalog

As a service to our members, this MSMS Physician's Catalog is a compilation of products, publications, and services produced by or available through the Michigan State Medical Society. It is designed to serve the needs of member physicians, their families, and staff.

# **FORMS**

### HCFA 1500 Forms



MSMS is a convenient and competitively priced source for the HCFA 1500 claim forms you need for medical billing in your

practice. One-part and two-part carbonless forms are available.

Two-part Forms: Each quantity of 1000 costs \$39.88 plus shipping & handling and tax. Item 101

One-part Forms: Each quantity of 1000 costs \$14.97 plus shipping & handling and tax. Item 102

## **Durable Power of Attorney** for Health Care Form



Now you can make advance decisions about your health care. Health care and legal groups urge every Michigan resident over 18 vears old to

complete a Durable Power of Attorney for Health Care Designation Form. The forms were developed and approved by the Michigan State Medical Society, the State Bar of Michigan, the Michigan Health and Hospital Association, and the

Michigan Osteopathic Association. The form provides a patient with the means to appoint a patient advocate to make health care decisions for them if they become incapacitated. Designation forms and accompanying brochures can be ordered in any quantity. The short patient brochure accompanying each form covers more detailed information about the Durable Power of Attorney for Health Care Law.

10 or less, \$2.00 per set 50-99, \$0.45 per set 100 and above, \$0.40 per set Item 103

# **EDUCATION AND RISK MANAGEMENT**

## Medical Records Information



In response to a recommendation by the Board of Directors and member interest. MSMS has published Medical Records Informa-

tion, a January 1999 report that provides an overview of legal, ethical, and practice management issues regarding medical records. The MSMS Risk Management Committee has studied issues in need of clarification for physicians and legal counsel. The report is presented in six sections:

- 1. Access to Medical Information
- 2. Release of Medical Information
- 3. Responding to a Subpoena
- 4. Appropriate Copying Fees
- 5. Retention of Medical Records in Physician Practices
- 6. Computerized Records

30 pages

\$24.95 for members ordering additional copies and all non-members Item 104

## Fraud & Abuse **Prevention:** What Physicians **Need to Know**



This handbook was created to provide general information on how physicians risk proof their practices in reaards to fraud and abuse issues

such as:

- Creating a compliance program
- Reference guide to civil sanctions, criminal laws, and penalties
- What carriers are looking for
- What to do if you become the target of an investigation

40 pages

\$20 Non-members \$30 Item 105

## **E&M** Documentation: **Tools, Tricks & Helpful Hints**



If you were unable to attend the E&M Implementation workshop, you can still get a copy of the handbook that was distributed during the event. Participants found

the handbook to be a very useful reference for creating office tools that would improve E&M documentation in the office. Contents include examples of matrix and progress notes used in offices to simplify the E&M documentation process as well as modifier situations that physicians need to be aware of.

29 pages

\$15 Non-members \$25 Item 106

# **CASE STUDIES**

MSMS co-sponsored studies relevant to physicians and the business of medicine detailing lessons learned from the experiences of physician practices around the country.

Each case study sells for \$25/Members; \$95/Non-members



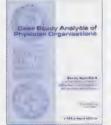
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Case Study Analysis of Physician **Practice** Mergers

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Case Study Analysis of Physician

**Organizations** (POs) 82 pages

Item 107



Case Study Analysis of Management Services **Organizations** (MSOs) 82 pages Item 109

WATCH FOR THESE UPCOMING **CASE STUDIES:** 

- Faculty Practice Plans
- Organizations in Crisis: Impacts, Considerations and Strategies for Physicians

Michigan State Medical Society PHYSICIAN'S CATALOG



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**Item 112** 

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# MSMS BOOKSTORE

# Renegotiating Health Care: Resolving Conflict to Build Collaboration

\*Leonard J. Marcus, PhD, Janice B. Wyatt, Barry C. Dorn, Phyllis B. Kritek, Velvet G. Miller

A practical guide to collaboration in a period of intense change within the health care industry. It presents effective tools for understanding conflict, negotiating differences, and creating a workable balance among those who deliver, receive, administer, and oversee health care. 453 pages

Hardcover, \$36.95

Item 116

\*Author's Note: Leonard J. Marcus, PhD, of the Harvard School of Public Health, is a speaker for the MSMS Leadership Skills Series.

# Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine

Albert R. Jonsen, William J. Winslade, Mark Siegler



Concentrates on strict adherence to ethics in the practice of clinical medicine, addressing such issues as informed consent, truth-telling, confidentiality, end-of-life care, pain relief, and

patient rights. 206 pages

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### Michigan State Medical Society PHYSICIAN'S CATALOG

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Anna M. Curren and Laurie D. Munday Reviews math principles essential to pharmacology including drug measurement systems, deciphering oral medication labels, and more. 315 pages

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Anthony S. Fauci, Editor in Chief



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sections, and NANDA-approved nursing diagnosis appendix. 2439 pages

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checklist of compliance activities. Order a copy through the AMA's Web site (http://ama-assn.org) or by calling (800) 262-3211.

Without a doubt, the administrative burden of Y2K compliance is monumental. But be reassured that no company is exempt from these problems and compliance issues. Physicians have not, by any means, been singled out. All businesses are in the same boat. Experts estimate that U.S. businesses will have spent more than \$500 billion by 2000 to resolve Y2K-related problems, including inadequate software and hardware, lost productivity, and the

resulting litigation. General Motors and Amoco Corp., for example, have each already spent more then \$100 million on compliance projects.

For physicians, MSMS is planning Y2K compliance seminars soon. Watch your weekly Medigram for more details and sign up as soon as you can. You have six months before the new millennium is here!

For those of us who are unprepared for Y2K, now is the time to take action. Think of Year 2000 computer problems as an east wind. You can't argue with an east wind. All you can do is prepare for it. Colleagues, it's time to put on your overcoats.

#### Let's Talk

Yes, there are physicians who have diligently prepared for Y2K. I would like to hear from you. Perhaps others can benefit from your advice. How have you addressed the problems? What specific actions have you taken? We'd like to publish them in a subsequent edition of this magazine. Please send an email to ksawhney@msms.org.

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# Squash the Millennium Bug

Krishna K. Sawhney, MD MSMS President



m There is no good in arguing with the inevitable. The only argument available with an east wind is to but on your overcoat."

— James Russell Lowell (1819-91)

You're as tired of hearing about it as I am, but the inevitability of Year 2000 computer problems can't be ignored by physicians. Unfortunately, statistics show that it is.

Surveys show health care has one of the worst preparation or "compliance" rates for Y2K. Shouldn't it have one of the best, given the importance of what we do?

A 1997 survey by the Gartner Group, for example, found that hospitals and provider groups are one of the least prepared of all industries surveyed for Y2K problems. Another 1998 survey found that more than 90 percent of physician practices were not yet addressing Y2K computer problems.

For a physician's office, with a handful of PCs, Y2K compliance should be relatively simple, but important. Not only computers, but all medical and non-medical equipment will have to be tested or certified as Y2K-compliant. But you're not done vet.

Perhaps the real source of business interruptions will come from outside, as a result of the potential effect on infrastructure: power, phones, and other services. Granted. that's not your fault. But it is your responsibility. You must be able to demonstrate contingency plans to deal with others' failings.

Why must you do anything at all to comply with this crazy Y2K debacle that seems overblown, ridiculous and something out of a bad scifi movie?

Because it's the standard of care. The "reasonable man" standard requires that you, as a physician in practice, take reasonable Y2K-compliance steps and allocate appropriate resources to address anticipated problems.

Experts warn that failure to take any action to address Year 2000 Problems within your practice adversely will impact your ability to maintain the standard of care and will create additional legal exposure.

What should you do to reduce your legal exposure?

- Designate a Y2K point person in your office. This is a substantial administrative task, which will include a full-scale internal and external assessment of compliance. Don't be surprised if a full-time person is needed for the task, especially if you're just getting started.
- ◆ Contact suppliers about Y2K compliance. The AMA recommends preparing a letter to send to all technology (medical and nonmedical) equipment vendors. Ask them to respond with a description of how they are approaching the problem. Beware of those who don't respond. Contingency plans will be needed.
- ♦ Medical equipment is a particular concern. Since most medical equipment has microchips, the malfunction of these devices could result in significant liability. Make a list of the medical equipment and contact each manufacturer and ask for proof of Y2K compliance. Use

Web sites as validation, not as proof, that your manufacturer is compliant. The proof is in the letter to your office.

- Payment and billing compliance should be addressed with third-party pavers. Outsourcing or manual back-up billing are alternatives if you're not compliant.
- ♦ Contingency planning is a must because of the scope of Y2K problems. Consider what you would do if particular systems fail. Consider the trigger dates for transitioning from non-compliant to compliant
- Other liabilities you should review are corporate directors and officers liability and contract liability. Directors and officers (of your own or another corporation) have a legal obligation to act prudently in operating corporations. Failure to respond appropriately to Y2K problems can lead to personal liability for damages suffered by the corporations. Regarding contracts, existing ones should be reviewed for potential liability.
- ◆ Document all Y2K compliance steps you have taken. This is very important, the experts say, in showing you have met the standard of care and in defending against any lawsuits. If you have any questions about Y2K compliance or documentation, please call MSMS' Computer Operations Department.
- Get a copy of the AMA's publication The Year 2000 Problem: Guidelines for Protecting Your Patients and Practice. This is a practical booklet that contains a useful continued on b. 67

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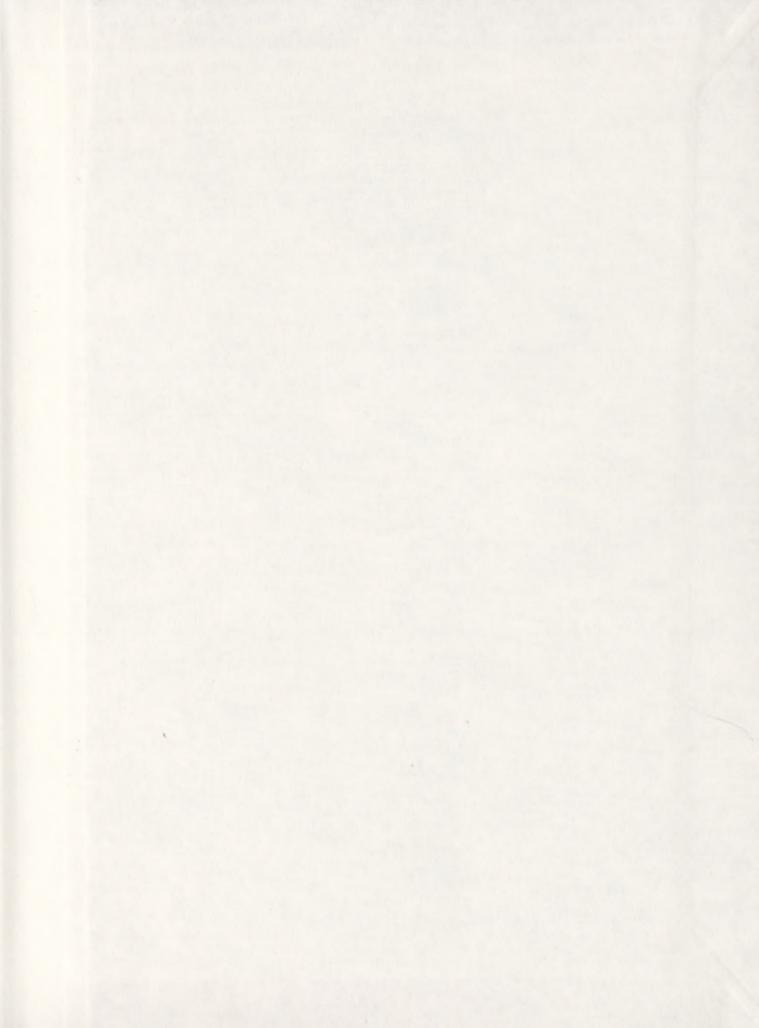


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